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ABSTRACT

This volume is primarily devoted to activities administered by the Assistant Secretary for Health. These programs include the Health Services Administration; the Center for Disease Control; the Alcohol, Drug Abuse, and Mental Health Administration; and the Health Resources Administration. Programs affecting education that are discussed include health education programs and alcohol education programs. (JF)

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1975

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

SECOND SESSION

SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS

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WEDNESDAY, MARCH 20, 1974.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

WITNESSES

DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH
DR. HENRY E. SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH
WILLIAM E. MULDOON, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, OAM/PHS
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HAROLD O. BUZZELL, ACTINF ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. FLOOD. Now we have the Assistant Secretary for Health. The presentation will be made by Dr. Charles C. Edwards, Assistant Secretary for Health.

I see we have a biographical sketch of you we will insert in the record at this point.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH OF ASSISTANT SECRETARY FOR HEALTH CHARLES C. EDWARDS, M.D.

Birthplace and date: Overton, Nebr., September 16, 1923.

Education: University of Colorado, Boulder, Colo., 1945, Bachelor of Arts; University of Colorado, Denver, Colo., 1948, Doctor of Medicine; University of Minnesota, Rochester, Minn., 1956, Master of Science, Surgery.

Experience: Present, Assistant Secretary for Health; 1969–73, Commissioner, Food and Drug Administration; 1967–69, vice president, Booz, Allen and Hamilton; 1964–67, director, Division of Socioeconomic Activities, American Medical Association; 1963–64, director, Division of Environmental Medicine and Medical Services, AMA; 1962–63, Council on Medical Education and Hospitals, American Medical Association; 1961–62, instructor of surgery, Georgetown University Medical School and Consultant to Public Health Service; 1957–61, teaching staff, Iowa Methodist Hospital and Mercy Hospital, Des Moines, Iowa; 1956–61, private practice, Des Moines, Iowa; 1950–56, surgical fellow, Mayo Foundation, Rochester, Minn.; 1949–50, teaching fellow, University of Minnesota, Department of Physiology; 1942–46, lieutenant, U.S. Navy, Korea.

Association memberships: American Board of Surgery, American College of Surgeons, American Public Health Association, Institute of Medicine of Chicago, American Medical Association, Economics Club of Chicago.

Awards: Silver and Gold Award, University of Colorado Alumni Association, May 1972; Founders' Award, Grant Hospital, Chicago, Ill., October 1972; honorary chancellor of Florida Southern College for 1973 and Honorary Doctor of Laws Degree—February 1973.

Mr. FLOOD. Do you have some people you would like us to meet?

Dr. EDWARDS. On my immediate left is Mr. Muldoon who heads our budgetary effort in the Office of the Assistant Secretary. On my right is Dr. Simmons who is the Deputy Assistant Secretary and also Director of our PSRO program. Next to him is an old favorite of yours, Mr. Miller.

Behind me are the agency heads. Dr. Stone of the National Institutes of Health; Dr. Egeberg of the Alcohol, Drug Abuse, and Mental Health Administration; Dr. Sencer, head of the Center for Disease Control; Mr. Buzzell, who heads the Health Services Administration; and Dr. Endicott, Administrator of the Health Resources Administration.

Mr. FLOOD. Doctor, you have a prepared statement. How do you want to handle this?

Dr. EDWARDS. It is your pleasure.

Mr. FLOOD. It is your show.

Dr. EDWARDS. Although the statement is time consuming, I think it lays out clearly some of the high points.

Mr. FLOOD. What do you want to do?

Dr. EDWARDS. May I read it?

Mr. FLOOD. Proceed.

Dr. EDWARDS. Mister Chairman and Members of the Committee: I welcome the opportunity to appear before you as you begin consideration of the health portion of the 1975 budget for the Department of Health, Education, and Welfare.

In view of the fact that you will examine very closely each of the elements of this budget request over the next several weeks, I believe it would be most appropriate for me to focus my remarks on the broad policy issues and decisions that underlie our budget strategy.

FOCUS OF LEADERSHIP FOR THE HEALTH ACTIVITIES

And in that connection first let me say that I believe one of our most serious problems—one that prevades every aspect of the Federal health effort—has been the lack of what might be called a central focus of leadership for the health activities carried out by the Department of Health, Education, and Welfare.

I have no desire to dwell on the past, except to the extent that hindsight can give us a better sense of the direction we need to take for the future. But I think it is accurate and realistic to say that this Department, insofar as its health-related activities are concerned, has done a less than effective job of developing a comprehensive strategy to carry out the major health responsibilities assigned to it by the Congress and the President.

PROLIFERATION OF HEALTH PROGRAMS

The incredible proliferation of health programs in the last decade alone, added as they were to an organizational structure and a catalog of health programs that have been growing over many decades, left the Department in dire need of a management and policy development system capable not only of administering its health responsibilities with efficiency and effectiveness, but also of determining whether specific programs were actually serving the health needs of the American people as they were intended to do.

We are now hopefully building that capability, and in so doing, we are gaining, for the first time, the ability to make sound analytical judgments about the real contribution of our efforts, about shortcomings that remain to be overcome, and about the potential for using the resources of the Federal Government to encourage and support needed change in the way the pluralistic American health system acts to preserve and promote the health of the people of this country.

I will not, at this time, detail the steps we have taken to transform the Office of the Assistant Secretary for Health into the central focus of health leadership to which I referred a moment ago. Those specifics might be discussed more properly at a later time when the committee takes up the budget request for my office.

But I feel it is important here to stress the fact that the budget request now before you, while certainly not the product of a radically different concept of the Department's role in the field of health, is a document that reflects a new commitment to sound management and rational planning, and one that looks to the selection of priorities by the only appropriate criterion—namely, the benefit to the American people.

When I appeared before you a year ago, my tenure as Assistant Secretary for Health had just begun. At that time, I outlined some of the goals and structural changes that I anticipated for the Public Health Service to make it more responsive.

REALINEMENT OF THE PUBLIC HEALTH SERVICE

This year the realinements are in place. We have in the Public Health Service six operating agencies. These agencies are: the National Institutes of Health, which remains essentially the same with the exception of the manpower programs which were transferred to the new Health Resources Administration; the Food and Drug Administration which has not been changed; the Center for Disease Control, to which we have added the National Institute for Occupational Safety and Health; the Alcohol, Drug Abuse, and Mental Health Administration which consolidates into a new agency, programs that were carried out by the former Health Service and Mental Health Administration and the Special Action Office for Drug Abuse Prevention in the White House. The Health Resources Administration which was created by combining the health manpower programs formerly in NIH, the National Center for Health Statistics, the regional medical programs, the Hill-Burton program, the comprehensive health planning activities, and the former National Center for Health Services Research and Development; and finally the Health Services Administration, which includes the health services demonstration, development, and delivery programs formerly in the Health Services and Mental Health Administration.

All of these functionally alined agencies report to my office, and it is our responsibility to provide policy planning and overall leadership for each of them. This we are doing through a structure which I shall detail in subsequent testimony. It is important to note at this point, however, that the Office of the Assistant Secretary for Health is also the policy focus for health-related decisions affecting medicare and medicaid and for such high priority activities as the program to develop professional standards review organizations, to carry out nursing home improvement initiatives, and to coordinate the Department's activities pertaining to population affairs.

LEGISLATIVE PROPOSALS

Mr. Chairman, I believe the executive branch and the Congress together are now at the threshold of achieving some important and necessary changes that will substantially improve this country's health care system.

We have submitted legislation for a consolidated health planning program that authorizes the establishment of health system agencies composed of consumers, providers, Government officials, and others, which would prepare and implement comprehensive plans for health care delivery systems. New Health manpower legislation will be submitted to take the place of the present authorities, which expire on June 30. And, as you know, a comprehensive health insurance plan has already been submitted to the Congress to assure financial access to adequate health services for all Americans.

The 1975 budget reflects a number of important new approaches which I believe will help lay the ground work for changes in the health care system, and thus give comprehensive health insurance a far better chance to succeed.

PROFESSIONAL STANDARD REVIEW ORGANIZATIONS

One of the most important steps to increasing the effectiveness of our health care system is the professional standards review organizations effort. When fully implemented this program will involve a nationwide network of voluntary, nonprofit groups of local physicians who will be responsible for assuring the quality of inpatient health services provided under medicare, medicaid, and the maternal and child health programs. The peer review systems to be established through the PSRO's will review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of length and method of treatment. We have included $58 million in the 1975 budget for PSRO's, and we anticipated that we will have signed agreements with 120 PSRO's by the end of 1975.

HEALTH MAINTENANCE ORGANIZATIONS

Another way we are seeking to improve the health delivery system while still preserving the basic right of freedom of choice, is through encouragement of the establishment of health maintenance organizations. As you know, these organizations provide comprehensive health services on a prepaid, capitation basis with an emphasis on primary care and preventive services. In fiscal years 1974 and 1975, the Department plans to spend $125 million to develop HMO's, grants and contracts will be used to support feasibility studies, planning and initial development, and will provide limited operational subsidies for HMO's providing care in medically and underserved areas. Included in this $125 million is $50 million to capitalize a loan fund to be used to make loans and loan guarantees to assist eligible HMO's to meet their initial operating costs while building up their membership to a viable level.

EMERGENCY MEDICAL SERVICES

In the 1975 budget we propose to continue the emergency medical services program at a level of $27 million. This effort, to be initiated in 1974, is another example of how we are attempting to improve the existing health care delivery system. The current emergency medical care resources of the country are far from adequate, resulting in needless loss of life because of the inability to provide immediate and proper medical attention to individuals involved in accidents, poisonings, and suddent illnesses.

Federal assistance to plan, initiate, or expand systems of emergency medical services will be provided to State and local governments and other public entities. This program is intended to assist States and local communities to develop self-supporting systems to meet their own needs and not to establish a network of federally supported emergency-care systems.

NATIONAL CENTER FOR HEALTH STATISTICS

The successful implementation of these new programs I have been discussing—compresensive health insurance, professional standards review organizations, health maintenance organization, and emergency medical services—require sound statistical data and further research and evaluation of the methods to deliver health care and to reduce the costs of care. The National Center for Health Statistics will continue its efforts to gather accurate and extensive information about the health of the Nation's population. We have requested $24 million for its activities, an increase of $3 million over 1974. The increase will be directed toward the expansion of the Cooperative Health Statistical System initiated in 1973. Research and evaluation efforts will continue at a level of $42 million, and will focus on problems of access to health services among different socioeconomic groups and geographic areas, on the effects of health insurance on the demand for health services, and on reimbursement for services provided by paraprofessional health-care workers.

REGIONAL MEDICAL AND HILL-BURTON PROGRAMS

As I have already suggested, a rational assessment of our accomplishments and shortcomings clearly dictates that we should deemphasize or terminate some existing programs. Accordingly, there are no funds in the 1975 budget for the regional medical programs or for the Hill-Burton program of support for hospital construction.

The concept of the regional medical programs as provided in current legislation has not provided a successful means of changing health-care delivery systems. This legislation expires in 1974 and we will not seek extension of it. The Hill-Burton program, conversely, has been successful. There is now an adequate supply of hospital bed for the Nation as a whole. We are now moving into an era where virtually all medical care will be funded through some type of insurance plans which will include compensation for depreciation of facilities. Thus, there is no need to continue this large-scale formula-based support program to encourage construction of hospitals. The Hill-Burton legislation expires in 1974, and we do not plan to seek extension of it.

COMPREHENSIVE HEALTH PLANNING

There is no appropriation request for the comprehensive health planning program whose legislative authority also expires in 1974. This does not mean we have given up on the support of health planning. On the contrary, as I have indicated, legislation has been introduced which will support a new system of health resources planning. We expect that the best elements of the health planning functions now carried out under the comprehensive health planning agencies, the State Hill-Burton planning agencies, certain of the existing regional medical programs, and some of the experimental health services delivery systems projects can be redirected and absorbed into a new system of regional health planning under the leadership of those who are closest to the problems and best able to plan for their solution.

COMMUNITY MENTAL HEALTH CENTERS

We are preparing to shift our emphasis from the direct support of community mental health centers projects which have proven successfully the concept of community-based mental health care. Liberal coverage for community-based care of mental illnesses under comprehensive health insurance will provide the financial means to support the continued operation of community mental health centers.

HEALTH MANPOWER

The budget embodies a major change in an approach to the financial assistance for the development of health manpower, and is in anticipation of new legislation to be submitted shortly to the Congress. It represents a shift away from institutional support to encourage expansion of enrollment at health teaching institutions. If the current level of enrollment in schools of the health professions is maintained we believe no significant shortages will develop in the coming years. For example, it is estimated that at current enrollment levels, by 1985 the number of physicians will increase by 50 percent and dentists by over 40 percent over the 1970 levels.

The focus of our new program will be on solving problems stemming from the decline of primary-care physicians, the geographic maldistribution of available health personnel, and the underutilization of paraprofessionals. In 1975 we plan to obligate $441 million for manpower activities.

ALCOHOLISM AND DRUG ADDICTION

The treatment of alcoholism and drug addiction have too long remained outside of the mainstream of the health delivery system. We are continuing to support research into better methods to treat and control alcoholism. Since 1971 we have been supporting, generally on a

3-year basis, community demonstration projects which have been directed toward a better awareness of the problems, toward better methods of dealing with alcoholism problems in special population groups, such as Indians, and toward fundamental improvement in the methods of treatment and rehabilitation of alcohol abusers.

In 1975 we will contract with profitmaking institutions to organize and establish alcoholism treatment programs in private industry which can later be supported by private health insurance programs. Assistance will be given to States to implement the "Uniform Alcoholism and Intoxication Treatment Act," and we will continue to fund selected projects aimed at special risk populations. The States will continue to receive assistance in conducting their own treatment and rehabilitation efforts through the State formula grant program.

It is perhaps too early to say whether we have turned the corner in the incidence of drug addiction. But I am able to report that treatment is available for all addicts who want it. Through the project and formula grant program we are providing a national treatment capability for 95,000 patients in 312 separate programs. Although the budget request for drug abuse will drop from $243.5 million in 1974 to $216.6 million in 1975, we still will be able to maintain the same level of treatment capacity in 1975. In 1975 all States will be providing drug treatment and services and they will be assisted through expanding the formula grant program which will rise from $25 million in 1974 to $35 million in 1975.

BIOMEDICAL RESEARCH

While there remains much to be done to improve the way in which health services are delivered, we cannot lose sight of the fact that scientific research is the key to better understanding of the causation of disease, and thus to its prevention and control. For that very reason, biomedical research remains a critically important part of our total health effort.

The National Institutes of Health commands the largest of the budget request for the six health agencies of the Department, representing nearly 40 percent of the funds we are requesting. The NIH budget request embodies continued major research and development initiatives in cancer and heart disease, the first and second leading causes of death in the United States. We are requesting an additional $95 million for the cancer and heart and lung programs. This will give us the authority to spend some $600 million on cancer and $309 million on heart and lung research in 1975. The budget request maintains the other research activities of the National Institutes of Health at about the same level as authorized in 1974 with the exception of a reduction in the general research support grant program.

Most of my attention thus far has been directed to those programs which are seeking to change and strengthen the health care system. Another important mission, of course, is to prevent disease.

CENTER FOR DISEASE CONTROL

The Center for Disease Control over the years has concentrated its efforts on assisting State and local health organizations in reducing the spread of communicable diseases, in providing protection against environmental hazards, such as lead-based paint, and in improving the health and safety of American workers. These efforts will remain at essentially their present levels in the 1975 budget request. We will continue our project grant support of venereal disease control efforts at a level of $24.8 million. The results of this control program are encouraging. The incidence of gonorrhea is still increasing, though not as fast as it has been, and we can expect it to level off next year. Significant improvement has been made in the control of syphilis, and we are now projecting a slight decline in the incidence of infectious syphilis in the coming year.

NEW HEALTH EDUCATION EFFORT

In 1975 we are requesting $2 million for a new health education effort. It is our goal to establish a central point to coordinate the ongoing health education programs of the Federal Government and to explore the feasibility of forming a National Center for Health Education in the private sector.

NATIONAL HEALTH POLICY

We are beginning, I think, to develop a working partnership among the executive and legislative branches of the Federal Government, State and local governments, the leadership of the private health sector, the academic community, industry, and consumers of health services, each of whom can and should have an effective voice in the development of national health policy and the strategic plans for carrying it out.

In summary we are requesting of this committee a total budget authority of $4.1 billion in 1975 for the programs of the Public Health Service.

I welcome the opportunity to appear before you, and my associates and I are ready to answer any questions the committee may have.

Thank you.

Mr. FLOOD. Thank you.

REORGANIZATION OF HEALTH AGENCIES

Dr. Edwards, the health agencies down at HEW have gone through repeated organizations in the past 10 years and the latest reorganization seems to put us back where we were two or three or four reorganizations ago. Don't you think it is about time we declared a moratorium on further reorganizations, have one more reorganization against any more reorganizations, something like that, and get down to the business of finding out how to improve the health of the American people and skip these reorganizations? Somebody is making a career out of them.

Dr. EDWARDS. I agree 100 percent.

Mr. FLOOD. Do you want to say anything more than yes?

Dr. EDWARDS. I am like you. I haven't been quite as closely involved for the past 10 years, but I have been very much interested in and fairly involved, and I certainly agree with you that there has been far, far too much in the way of organizations and reorganizations.

There are times when reorganizations are certainly very appropriate, but I think at this point in time we have done all of the reorganizing we need to do, and we need to get on with our business. That is what we are trying to do right now.

Mr. FLOOD. Did I write that for you?

Put in the record a chart showing the current reorganizations of the health agencies, just the health agencies.

[The information follows:]

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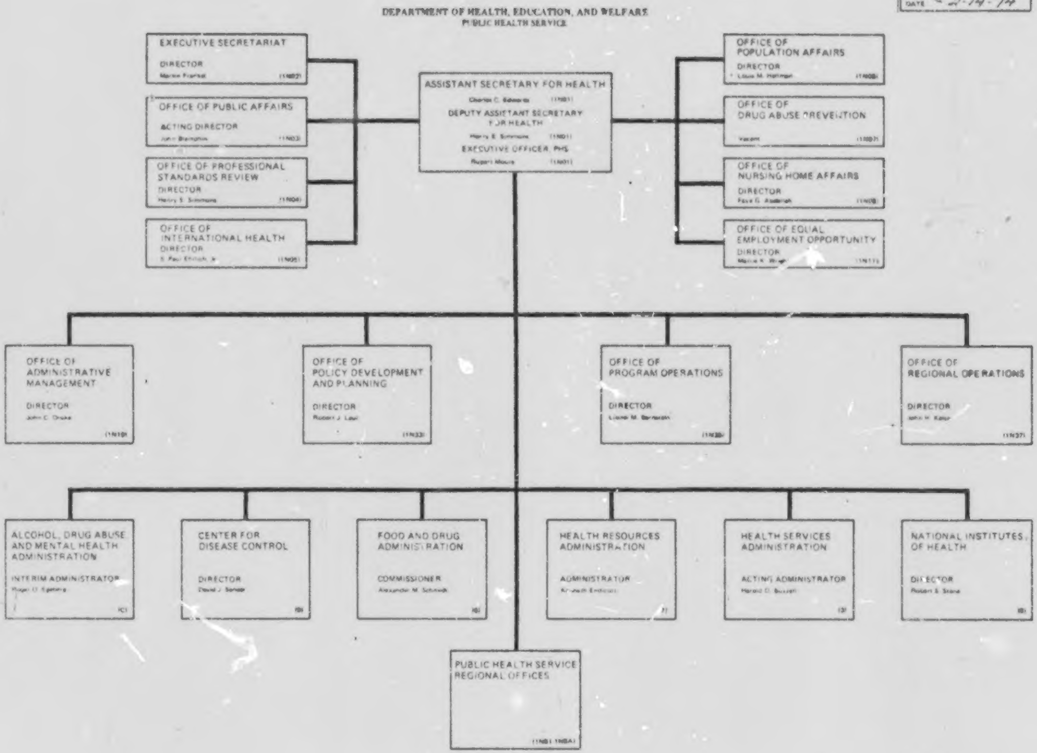
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NATIONAL INSTITUTES OF HEALTH
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Robert S. Stone
PUBLIC HEALTH SERVICE REGIONAL OFFICES

We have a great many complaints, and that is an understatement, about the reorganization of the regional offices, and particularly about the maternal and child health staff, the way they are being treated and kicked around. There is no doubt in my mind that you are receiving the same kind of complaints. I don't think there is any question about it.

Will you please explain how you are reorganizing the health staff in the regional offices where there is so much, very much opposition to it.

Dr. Edwards. Mr. Chairman, as you know, whenever you make some changes there is always some opposition.

Mr. Flood. Some changes I am for. A new elevator operator now and then.

Dr. Edwards. To say that the maternal and child health constituency is not well organized would be one of the great understatements of the day. They are well organized, and some of the changes have disturbed them. We believe, though, the general organizational setup of our regional offices makes sense. Previously all of the regional health administrators reported to the Director of the Health Services, Mental Health Administration. We felt the first change that had to be made was that the regional health administrators should be reporting to the Assistant Secretary for Health because they did not represent just one agency.

Mr. Flood. That is you.

Dr. Edwards. Right. They did not represent one agency but all of the agencies in the region. So that was the first thing we did.

We then set up in my office, a small office, the Office of Regional Health Affairs, which in a sense did not get involved itself with the programmatic activities in the regions but nevertheless was the focal point for transmission of information and budgetary data, allocation of resources, and so forth.

In addition to that, we renamed the top health man in the region and gave him a new title, the Regional Health Administrator, giving him line responsibility over the health activities in each of the regional offices. We felt we had to have someone at whom we could point the finger who we knew had the responsibility for seeing to it that the programs in the regions were appropriately implemented. This in essence is the philosophy behind what we have done.

We have moved away a bit in the regions, as we have here in headquarters, from the categorical approach to all organization matters to a more flexible approach where from the managerial point of view we feel it allows us to use our resources more adequately, allows the managers to use their manpower resources in a more appropriate way, and permits us to deal with matters that have created some problems in connection with some of our constituency. But nevertheless we do in all of the regions and here at headquarters have specific managers in charge of definite programs. So I think many of their fears are ill founded.

MATERNAL AND CHILD HEALTH STAFF

Mr. Flood. What is ill founded about the fears of the people in the Maternal and Child Health staff?

Dr. Edwards. I think they think in a sense we have lost interest in that program, which is not true at all. We feel it has a very high priority. But part of this also is that there has been more than a small amount of concern on their part about the administration's decision to move from a project grant operation to the formula grant operation. This too has created some problems.

STAFFING AT THE NATIONAL INSTITUTE OF MENTAL HEALTH

Mr. **Flood.** We have also been told pretty much that the staffing at the National Institute of Mental Health is being cut back drastically. As a matter of fact I wrote a letter to Secretary Weinberger on that. Is it a fact that—we call it NIMH—that they got an 18-percent cut in staffing? Mental health is a big deal and NIMH is going to be a big thing. Up comes a message everybody is for it, and it gets cut 18 percent.

Why in view of all of this do you single them out for such a large reduction in staffing? That is a kiss of death. The worse thing, in other words, that can happen at NIH is have somebody say we are for you, and bang.

Dr. **Edwards.** I think it is fair to say that originally our 1974 position ceiling may have required a cutback. This has been rescinded, and at this point in time we are not planning any employment reductions.

Mr. **Miller.** As a matter of fact we notified the Congress yesterday that we would make sure that there would be enough employment in the NIMH.

Mr. **Flood.** Yesterday?

Mr. **Miller.** Not in writing. We ratified several congressional sources by phone calls made yesterday, Mr. Chairman, that we would make sure there would not be a reduction in force in the Alcohol, Drug Abuse, and Mental Health Administration.

Mr. **Flood.** Who did you call up here, the Subcommittee on Agriculture or what?

Mr. **Miller.** Members of the Maryland delegation.

HEALTH PROGRAMS BUDGET, 1975

Mr. **Flood.** The 1975 budget for health programs, the whole works, certainly does not look very impressive to many people despite all of the rhetoric. In fact, I have heard many experienced observers, some of the long-haired, flatheeled boys that know this business, say this year's health budget is worse than last year's. If you can imagine anything worse than that you are under the gun. How much influence did you have on this 1975 budget?

Dr. **Edwards.** I think we—when I say "we" I mean myself and the agency heads—have had significant influence in the development of the budget. I would be less than frank if I said the budget reflected all we wanted, and I suspect it is probably true as with most budgets that operating people are never totally satisfied. I wouldn't categorize this certainly as a disaster budget like I would have last year's. I think there are some things in it that you can question in terms of the adequacy of some of the funding. But I think in light of some of the budgetary problems it is a pretty good budget.

REDUCTION OF A HALF A BILLION DOLLARS

Mr. FLOOD. Don't you feel—you don't look it, but don't you feel that you have any visceral sensations about defending a budget which reduces appropriations for health agencies by over half a billion dollars? That impresses even the Appropriations Committee—half a billion dollars.

Dr. EDWARDS. I hadn't looked at it quite in those terms.

Mr. FLOOD. I guess not. But all of those round figures, half a billion, and you don't feel uncomfortable at all about coming up here with it?

Dr. EDWARDS. There are obviously certain parts of the budget that, as a health professional, I am less than comfortable with, but I think it has to be looked at on a program by program basis to assess the impact of the half a billion dollars difference.

I think we have to look further into that half billion dollars. It is important to recognize that approximately $315 million of this $500 million represents hospital construction grants the Hill-Burton program. We have not included Hill-Burton in the 1975 budget.

I also think it important to point out that while we have not included it, there is currently available in our budget for hospital construction about $570 million and in 1975 about $317 million will be available. Although on paper there is $200 million less in our budget for hospital construction, the pipeline will be fairly full.

I think it also important to point out that included in that half billion is the reduction in health manpower.

We are proposing that capitation not be eliminated but be reduced. The capitation amounts to about $36 million of the half billion dollars.

The other two items I would want to mention are comprehensive health planning and the regional medical program which represent about $112 million in this year's budget. We are not going to propose that much for health planning for 1975, but once we get legislation we will be requesting funds for it. These are not reflected in our current budget for 1975.

In the final analysis there is no question that there is a reduction.

U.S. HEALTH STATUS

Mr. FLOOD. Here are some statistics we picked up. I will read them to you.

To date, the United States ranks 14th in infant mortality, 11th in maternal mortality, 22d in life expectancy for men, 7th in life expectancy for women, 16th in the death rate of middle-aged men, 8th in doctors per population.

This is the United States of America I am talking about. With all this Nation's resources, with everything everybody says on the Fourth of July, why doesn't our health record look better than that?

Dr. EDWARDS. It is difficult to argue with these statistics, Mr. Chairman.

Mr. FLOOD. That is right.

Dr. EDWARDS. Again, one has to compare apples with apples and oranges with oranges. I think one has to recognize the heterogeneous population that is present in this country. The number of people that we have in our population in this country is far larger than some of the countries that are ahead of us in the statistical race, if you will.

I think overall, although I cannot argue these figures specifically——

Mr. **Flood.** You have discussed derivation of ancestry as among groups. Here we are supposed, after all these years, to breed out the bad. It is supposed to be much, much better. It was your speech. I read it.

Dr. **Edwards.** I would not go quite that far.

Mr. **Flood.** That is the theory.

Dr. **Edwards.** To make this really realistic, I think we have to compare Swedes with Swedes, and so forth.

Mr. **Flood.** In Sweden.

Dr. **Edwards.** In Sweden, yes.

My whole point is that I do not think these statistics accurately reflect the true state of health in this country. That is not for a moment to suggest that we haven't a long way to go to put ourselves in the position we would like.

PHYSICIANS PER CAPITA

Mr. **Flood.** Let us take the last item. What has it to do with Sweden? We are eighth in doctors per population. Take Sweden or whatever you want, what about that one?

Dr. **Edwards.** Dr. Endicott might like to speak to that. I am not sure who are the seven above us.

Mr. **Flood.** Do you want to settle for seventh?

Dr. **Endicott.** Israel is one which has a higher ratio. They have had an excessive migration into their country.

Mr. **Flood.** That is exhibit A.

Dr. **Edwards.** We run into the problem that someone was telling me this morning. In the Philippine Islands, as an example, there are probably as many doctors in non-medical jobs including driving taxicabs as there are practicing medicine.

Mr. **Flood.** Except the ones that come here from someplace else.

Dr. **Edwards.** Right. But they have more physicians per capita in the Philippine Islands.

FOREIGN MEDICAL GRADUATES

Mr. **Flood.** Walking down the halls in our general hospitals, I do not know what they are saying. I do not know what town I am in.

Dr. **Edwards.** The point I was making is that our standards for medical education are much higher here. They turn out far more doctors in some of the countries that would rank ahead of us. As a result of that, I think in some of the lesser developed countries we do find the problem that doctors are not fully employed.

I think certainly here in the United States we fully employ our doctors.

BUDGET FOR NATIONAL INSTITUTES OF HEALTH

Mr. **Flood.** I have heard that. That has been mentioned.

The budget, again, proposes increases for the National Cancer Institute and the Heart and Lung Institute, but a reduction for all the other Institutes in NIH. Cancer, Heart, Lung. Everybody else gets a reduction. How can you defend such a budget for NIH? We had all these buildings set up. This subcommittee had a lot to do with it.

Dr. **Edwards**. Let me speak to that, if I might, Mr. Chairman.

Mr. **Flood**. When we first came here, it looked like Yankee Stadium out there. We know everyone of those buildings out there.

Dr. **Edwards**. We certainly recognize that there are significant increase in both the Cancer and the Heart and Lung Institutes' budgets. The point I would make is that the priorities that have been given to the Cancer Institute and to the Heart Institute are priorities that were established both by the Congress and by the President. We have had no control over that.

Actually, the budget of the NIH represents—Dr. Stone can speak to this—a significant increase in cancer and heart. The rest of the Institutes have stayed, for all practical purposes, about level.

We have eliminated this year, I think very justifiably, approximately $44 million in research resources which is the general research support grants. I think a good case can be made for the elimination there. The other Institutes have stayed where they were, status quo.

Mr. **Flood**. Did you ever hear about inflation?

Dr. **Edwards**. Yes.

Mr. **Flood**. It hasn't stayed very still, has it?

Dr. **Edwards**. Dr. Stone and I have argued at some length about the need to maintain balance among programs at the National Institutes of Health. I think we have to be very careful that we do not give priority programs so much funding, particularly at the expense of other programs. I think we are bordering on that at this particular point.

HILL-BURTON GRANTS

Mr. **Flood**. One of the most controversial things in your budget is the elimination of the Hill-Burton grants. We understand your position is that there are already too many hospital beds. However, the American Federation of Hospitals tell us there is a shortage of 90,000 beds.

What are the facts? They are pros. You are always interested in pros. You are a pro yourself. You always go to bat for the pros. There is nothing wrong with that.

The doctors have not found out yet that they are not running the hospitals. They are run by the administrators. They know, and they say that they are 90,000 beds short.

Of course, they are special pleaders.

Do you have any statistics on that? If so, we would like to have them.

Dr. **Edwards**. I think you have given the hospital administrators' figures a little more credit than they are deserving of. I cannot tell you how they come up with this 90,000 figure. There is no question that we have shortages in certain categories. I think the inner city hospital problem is one in terms of both renovation and new beds.

There are spots where we do need more hospital beds. In toto, we feel the bed capacity is sufficient.

Mr. **Flood**. In toto. That is a very good word, but if you are not in that town, you are in trouble, especially with the gas shortage.

Dr. Edwards. This year, 1974, we have available over a half billion dollars in our Hill-Burton program. We will go into 1975, after having obligated about $250 million of that $567 million, with about $316 million in 1975 for hospital construction.

Mr. Flood. You mean modernization.

Dr. Edwards. It is in Hill-Burton, and it can be used either for new construction or for modernization. Most of it right now is being used for modernization.

HEALTH MANPOWER TRAINING

Mr. Flood. Another controversial proposal is the reduction in the support of the training of health manpower. The Secretary told us we are training too many people. He sat right in that chair and said it yesterday. We understand the NIH has studies showing there is a shortage of 30,000 doctors right now.

Do you have any statistics, or studies, or hard evidence to support the fact that we are in danger now of training too many doctors and health professionals? They tell us we need 50,000 doctors last night, we need 200,000 paramedics last night. Now there is a danger that we are training too many. What goes on?

Dr. Edwards. Mr. Chairman, I do not think there is a danger. There could conceivably be a danger of training too many. I do not think the Secretary meant what he said if he said there are currently too many doctors. I think what the Secretary——

Mr. Flood. You don't think Secretary Weinberger meant what he said?

Mr. Miller. I do not think he said "currently." I think he said there is a danger if we continue the way we are going.

PHYSICIAN OUTPUT BY 1980

Mr. Flood. Let's use rates instead of current figures, then.

Dr. Edwards. I think we have made rather significant strides over the last decade. I think we have increased the enrollment in our medical schools from approximately 8,000 admissions or graduations per year to about 14,000 or 15,000 in 1975. According to our calculations, if we continue the present output, by the 1980's we will have increased the supply of doctors in this country by approximately 50 percent.

I think that is probably what the Secretary was referring to. I am not even sure that will be too many.

The real issue is not aggregate numbers. The real issue, I think—and I believe most will agree—is, first, how do we distribute this number and what kinds of doctors do we train? Those are the issues we have to come to grips with.

We will try to put the emphasis over the next few years on getting more primary care physicians and getting a better distribution of them.

OUTPUT OF PARAMEDICS

Mr. Flood. What about your paramedics? Two years ago your people nearly broke down and cried about paramedics. Now they are closing places out in Seattle where they were doing this. There was a long waiting list from the AMA. The greatest thing since canned beer. Now they do not want paramedics.

Dr. EDWARDS. No. We want paramedics. I think not just the Federal Government, but the private sector as well, has been very slow in defining the role of the paramedic. As a result, we have not figured out how we are going to pay them. We have to better define what their role is to be and we have done a pretty poor job of this.

There is no question in our minds that we have to have the allied health professionals or paramedics if we are really to increase our utilization of doctors.

Mr. FLOOD. That is just what I said.

Dr. EDWARDS. I think the enrollment in our allied health schools is such as to indicate sizable numbers are being trained.

SHORTAGE OF HOSPITAL BEDS AND SUPPLY OF PHYSICIANS

Mr. FLOOD. I go out and make speeches and I say what you fellows say here. I come back next year and I wouldn't dare go back to that town again because it is a different story year after year. I am afraid to open my mouth, if you can believe that, but that is the way it is.

Dr. SIMMONS. There is some material on two of these points that Dr. Edwards and I have discussed before but which he omitted.

On the need for additional beds, it is very difficult to understand the figure that you have mentioned, given the fact that the American Hospital Association's own statistics in 1972 show a less than good occupancy rate for the Nation's hospitals, and that is falling. In fact, in hospitals under 100 beds, the occupancy rate in 1972 was 66 percent, and for 200 to 300 beds, 77 percent.

To run one efficiently, the occupancy rate is supposed to be 85 or 90 percent. It is pretty hard to be concerned that we have a shortage of hospital beds, although there may be locally.

On the total number of physicians, the figures that we have developed in conjunction with a lot of bright people on the outside show that our problem may not be answered by more physicians. There are already countries that have less physicians than we have who do much better than we do.

Mr. FLOOD. I have heard that argument before for 11 different reasons.

Dr. SIMMONS. That is right, just as there are 11 different reasons why the United States looks the way it does in certain mortality statistics. That is the point we want to make. It may not be that simple.

Mr. FLOOD. I got their story. Now I want yours.

Dr. EDWARDS. In the allied health professionals——

Mr. FLOOD. I did not ask them. I just took the figures.

Dr. EDWARDS. I think the fact that we are not recommending capitation and recommend decreased funding for this in no way indicates that we have lost interest in this particular operation. It is just that we feel these people can probably provide for their own education through other mechanisms.

Mr. FLOOD. I tell you something else the Secretary told us. He told us that the legislative and the budget proposals for health manpower will do the following things: maintain current training practices, encourage better geographic distribution of medical personnel, increase the proportion of new doctors trained in the delivery of primary care, a point you were about to make, make better use of paraprofessionals, attract more women and minorities into the health professions. That is about everything I was thinking about saying. He told us the President's budget proposals will do all those things.

Will you please tell us how it is possible to do all those good things with less money? Also tell us specifically which of the legislative and budgetary proposals that he talks about would accomplish each of those objectives.

Dr. EDWARDS. I think what he was referring to is that we have built up, principally through capitation over the last 6 or 7 years, a student level in our medical schools that we feel is adequate to provide the numbers of physicians that we need over the next decade.

Mr. FLOOD. When you cannot get into a medical school with a shoehorn?

Dr. EDWARDS. That is true, it is very difficult to get into medical school.

Mr. FLOOD. Very difficult.

Dr. EDWARDS. But just because it is difficult to get in does not necessarily mean that we should be building more medical schools.

Mr. FLOOD. All right. Go ahead.

Dr. EDWARDS. I think he was also referring to the proposal that we will be submitting to the Congress very shortly on health manpower and that is that it will do the things that he outlined including maintaining current capacity.

Mr. FLOOD. Everything that I said he said.

Dr. EDWARDS. Yes. I think he was referring to the manpower legislation proposal that we will be submitting to the Congress.

CAPITATION GRANTS

Mr. FLOOD. The budget calls for a phasing down of the capitation grants for schools of medicine, osteopathy, dentistry, nursing, and so on, but it seems to assume that the schools will be able to make the proper and necessary financial adjustments.

How can these schools that we are talking about take all those cuts when they are all broke? How do you do that? With mirrors?

Dr. EDWARDS. First of all, I do not think they are all broke.

Mr. FLOOD. I can think of three.

Dr. EDWARDS. I can also think of three. You are right there.

Mr. FLOOD. I can think of three that are not broke. Three and a half.

Dr. EDWARDS. I think we have to ask ourselves if some of their financial problems are not of their own creation?

I have never seen a medical school yet that I felt was operating in the most efficient fashion that it could. I think there is still some fat in most medical school budgets. We feel strongly that we have to maintain some level of capitation support.

I think we can rely, particularly in State schools, on increased tuition, and I think some States have assumed a much greater role in the financing of medical education than others.

I think across the board, States can probably do a better job than they have been doing in supporting medical schools.

I think this fills the slack for the amount we are reducing in capitation plus what they are able to generate by increased tuition and increased State support.

TRAINING GRANTS AND FELLOWSHIPS

Mr. Flood. You did not have anything to do with last year's budget, but you do now. Last year the budget proposed to eliminate training grants and fellowships in all fields of medical research across the board, but Congress did not adopt that proposal. Funds were appropriated to keep the training grants and fellowships alive.

Nevertheless, despite what Congress did, we continue to receive reports that all these programs are being discontinued. We specifically earmarked and appropriated these funds to continue the NIH training grants and fellowships. We wrote you letters about it and asked questions about it. There were terrific majorities for it in both Houses on both sides of the aisle.

Is this money being used for those purposes?

Dr. Edwards. Yes. We have cut back on some of our training programs. It might be well if Dr. Stone commented on this.

Dr. Stone. The money is being expended. The method of support is being changed from training grants to fellowships, Mr. Chairman. The money is being spent.

Dr. Egeberg. In 1974, training programs have been restored to approximately their 1973 level, consistent with the intent of Congress. This means that grantees will be receiving costs as well as funds for student stipends. We do not want to lose the faculties that have been built up.

Mr. Flood. Of course, that puts you in opposition to the school of thought about giving money to students instead of institutions, does it not?

Dr. Egeberg. In our categorical training programs, we think that it is essential to provide institutional support as well as student support. I should point out, however, that only stipends are paid in our expanded fellowship program.

Dr. Edwards. Certainly the 1975 budget has much more institutional support than did the original 1974 budget proposed by the administration. We have cut back some but, nevertheless, there is some institutional support.

NEED FOR SUPPORT OF RESEARCH TRAINING

Mr. Flood. Have you any better statistics or any concrete evidence as to the need for support of research training than you were able to give us last year? Last year it was lousy. Do you have anything this year? Of course, you had only been here 2 weeks. Is there anything better, this year, in the way of concrete evidence?

Dr. Edwards. You are speaking of research training?

Mr. Flood. To support research training. Last year's record was terrible.

Dr. Stone. We are installing mechanisms to produce those figures on a prospective basis. We have included in the reports of the training grants and fellowships and the other grant support, manpower reporting requirements that will give us better evidence in the future of manpower utilization from which we can project manpower needs.

Mr. Flood. OK, but when will we get it here?

Dr. Stone. We will not have those figures for several years, Mr. Chairman.

Mr. Flood. All we have to do is keep breathing?

Dr. Stone. I certainly hope so.

Mr. Flood. With the help of the Department of HEW.

Dr. Edwards. I think it fair to say, not just in this program, that we have not accumulated some of the evaluation statistics that we should have been generating over a long period of time if we ourselves are to have and if we are to give you the kinds of information you need to make these value judgments.

ARTHRITIS TRAINING GRANTS

Mr. Flood. In keeping with what you said, we already know, despite the intentions of our committee, the NIH reduced training grant funds in the fiscal year 1974 budget for the arthritis program. It is down now to 41 trainees this year from 84 in 1972. By next year the arthritis program will be about completely phased out. There will be only 4 trainees remaining in the whole shop.

Dr. Stone. Programs, sir, training grant programs. The number of individuals in fellowships will increase.

Mr. Flood. We have the phase, "training grant funds."

Dr. Stone. Funded.

Mr. Flood. F-u-n-d-s, training grant funds. That is what we have. What does that mean?

Dr. Stone. We will get you accurate information and make sure you have it.

Mr. Flood. All right. Let us determine the accuracy. Let's just get the information. We will weigh it in the balance.

Dr. Stone. All right, sir.

[The information follows:]

ARTHRITIS TRAINING PROGRAMS

	Fiscal year—		
	1973	1974	1975
Trainees (under institutional awards)	60	50	4
Postdoctoral and special fellowships	12	6	4
Research career development awards	10	10	8
Research career awards	1	1	1
Research training fellowships		14	28
Total	83	81	45

PEER REVIEW SYSTEM

Mr. **Flood**. We believe that the peer review system for reviewing research and training applications works pretty darned well, but there is one thing about it that concerns us. That is the danger that the members of the review panels may constitute a research establishment or fraternity, a closed corporation, a so-called "in" group which shuts out unorthodox ideas. I do not mean personalities. You do not like Joe Zilch because he comes from that school, or you knew him when. I do not mean personalities. I mean unorthodox ideas.

Every once in a while we get complaints here from a scientist who thinks he has a good idea, and he cannot get NIH support to pursue it because his idea is at odds with current conventional wisdom in that field. Whether he is a nut or not is something else.

Of course, very few of us are in a position to evaluate that one way or the other. The question is: Have you ever considered establishing an appeal board and, preferably, to have that appeals board comprised of scientists, recognized top-flight guys from other fields than the one this individual is in that we are worried about, to consider complaints of that nature?

With all the money we are spending on medical research, we may be shutting out just one brilliant but obscure innovator who may turn out to have the breakthrough for a great scientific idea. That worries us right along. What about that?

Dr. **Edwards**. I think your concern is very legitimate.

Mr. **Flood**. As an old trial lawyer, even I am for an appeals board.

Dr. **Edwards**. I have not thought about it per se.

Dr. **Stone**. Yes, sir, it has been discussed at NIH, and it is still under discussion.

Mr. **Flood**. That will be the end of that.

Dr. **Egeberg**. In case it is the end, which I doubt, there is an additional resource which should be considered. That resource is the dean of the medical school. The dean could provide funds for a year or so to prove whether or not the young investigator has something worthwhile that should be supported.

Dr. **Edwards**. I think your idea has merit, and I think we should pursue it.

Mr. **Flood**. This is nothing peculiar to NIH. I am on Defense appropriations. It is an establishment thing. Imagine being on Defense appropriations and HEW appropriations, robbing Peter to pay Paul. They have all kinds of appeals boards, real good, solid things, and not from the same outfit. They take a handful of people who are all top-level scientists.

Mr. Michel.

PROFESSIONAL STANDARD REVIEW ORGANIZATION

Mr. **Michel**. Let us go through your testimony and cover some of the items I have blocked out here.

You requested $58 million in the 1975 budget for PSROs, and you anticipate you will sign agreements with 120 by the end of 1975.

Question No. 1: What leads you to believe there will be 120 signed agreements in this coming fiscal year?

Dr. **Edwards.** May I ask Dr. Simmons to speak to that. He is the director of the program.

Dr. **Simmons.** There are 203 potential PSROs from the areas designated. We already have on file 300 letters from throughout the country from organizations interested in coming in to discuss planning contracts for PSROs. Is it an estimate? Is it very hard, really, to know.

Mr. **Michel.** What if we cut that figure in half; what would happen?

Dr. **Simmons.** I think it would seriously hurt the possibility of the program succeeding, frankly.

Mr. **Michel.** Would that be a popular move out in the country?

Dr. **Simmons.** Not among the public.

Mr. **Michel.** What does the public know about PSROs?

Dr. **Simmons.** They do not know too much about PSROs, but they do know increasingly about very serious problems in medicine. In fact, just last night I was reading over an article in Medical World News on "How Well Does Medicine Police Itself?" It is really a very shocking kind of article. It took a nationwide sample of how well the profession is doing in policing itself, finding where the problems exist and doing something about it.

This is just one of many more articles appearing in the medical and lay literature. There are problems, and some system has to be set up to take care of those problems that does not exist now.

I think as the public starts understanding that—I know responsible members of the profession already do—they realize that we have to establish a better system than we now have, and we should get at it. It is long overdue.

Dr. **Edwards.** We need a better quality control system than we have, not necessarily a better medical system, but a better quality control or peer review system.

Dr. **Simmons.** Right.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. **Michel.** Let me move on to HMOs. You say you plan to be spending $125 million in fiscal year 1974 and 1975. Is there any carryover amount involved here from 1974 to 1975?

Mr. **Buzzell.** I think so. I think the indication from the chairman was that perhaps covering the first two quarters of the next fiscal year.

Mr. **Michel.** Is that absolutely essential for you?

Mr. **Buzzell.** Yes, it is. We will not be able to start funding HMOs until probably June. We probably won't receive the 1974 supplemental before May or the middle of May. So, it would be essential that we have the 1974 supplemental authority in fiscal 1975.

Mr. **Michel.** If, perchance, the Congress really got moving and enacted some form of the administration's health insurance proposal, would that have any bearing at all on the funding requested in the HMO area?

Mr. Buzzell. No, it would not have any bearing in the sense that we would still need the HMO funds. The health insurance, while important, will in fact foster the growth of HMOs.

Mr. Michel. You anticipated the next question, which is: Then would such a program pretty much along the character and lines the administration is proposing tend to increase the kind of requests you would be looking for in the future for HMOs, or would that depend upon how many availed themselves of that substantive authorizing legislation and provided the mechanism for including HMOs in their programs?

Mr. Buzzell. As you know, the administration's request for the HMO program is pretty much up to the authorizing level. I think that is appropriate. Frankly, I do not think we are capable or have the capacity to launch a bigger program with or without comprehensive health insurance.

Dr. Edwards. I think your point, however, is good. A national health insurance program, whether it be the administration's or another one, I think definitely will increase the interest in or the movement of the HMO concept.

Mr. Buzzell. As you know, the HMO legislation really is not tailored to the working poor and to the disadvantaged people. As a consequence, we are very anxious to see the comprehensive health insurance proposal enacted from the inception of the HMO program.

Dr. Edwards. It would really bring the lower income groups into the mainstream of good medical care.

Mr. Michel. Currently, is it not a little impractical for the HMOs to be really effective in that area?

Dr. Edwards. In that area?

Mr. Michel. For the low-income people.

Mr. Buzzell. With one major exception. It is not impractical in terms of serving the current medicaid population, and that is a big population.

Aside from that, you are correct, it is impractical from the viewpoint of what I would classify as the working poor.

HMO'S IN MEDICALLY UNDERSERVED AREAS

Mr. Michel. Dr. Edwards, in your testimony you speak of grants and contracts used to support feasibility studies, planning and initial development, and to provide limited operational subsidies for HMOs providing care in medically underserved areas.

How long will it take us to get the results of those studies?

Dr. Edwards. It is difficult to put a specific time on that. We are talking about a 10-year program. These things will not be accomplished over the next year or even 2 years.

Mr. Michel. For the sake of the record, I think we ought to have that brought out. Reading this testimony, you would think we already have somebody in mind for a contract or a grant, and within a year's time they will put something together, and by the next year we are ready. It is a long-range proposition, is it not?

Dr. Edwards. I do not think there is any question that it is long range.

Mr. Buzzell. I would like to qualify the record just a little bit. As you know, we have a number of HMOs out there that have completed feasibility studies. There are a number of HMOs that are now ready to go operational. The law specifies that we assist those HMOs during their first 3 years of life. We have some that will quickly benefit from our assistance.

HMO'S CURRENTLY SUPPORTED WITH FEDERAL FUNDS

Mr. MICHEL. How many are currently in being that are supported with Federal funds?

Mr. BUZZELL. At the moment, we have 41 that are currently spending moneys from grants that we have made.

Mr. MICHEL. Could we have placed in the record a summation of two or three that you consider to be good, prime examples you would like to talk about from time to time?

Mr. BUZZELL. Yes. We are just completing a survey of the existing grantees, and we would be glad to do that.

Mr. MICHEL. Then feel free in the record to expand on those which are not panning out so well, where you have real problems.

Mr. BUZZELL. May we have permission to wait a few weeks in terms of that submission?

Mr. MICHEL. The record will probably be open for a period of time. If you can get the information before the record is closed, we would like to have it. If you cannot, obviously you cannot. Do the best you can.

[The information follows:]

EXAMPLES OF HMO PROJECTS

FOUR SUCCESSFUL HMOS

Group Health of Arizona, Tucson, Ariz.

This is a consumer-sponsored HMO assisted with HEW grant fund totaling appproximately $500,000 during the last 2 years. The HMO became operational in January 1974, and is a prepaid group practice model serving employees in Tucson. Enrollment has increased in the last 2 months to about 8,000 on March 1. There is strong local commitment both for the planning and financing of this plan by a significant portion of the Tucson community. The entire plan started without an existing structure and has managed to attract physicians and renovate a clinical facility to deliver prepaid health care.

Long Island Jewish Medical Center, New Hyde Park, N.Y.

This is a hospital-based HMO assisted with approximately $200,000 in HEW grant funds which became operational in conjunction with Blue Cross in December 1973. Current enrollment is about 4,700. The plan is known as the Blue Cross Community Health Plan. Physician facilities close to the hospital were recently renovated for the delivery of primary health care.

Lovelace-Bataan Health Program, Albuquerque, N. Mex.

As a large multispecialty group practice and hospital complex, Lovelace-Bataan HMO became operational by converting part of its service to prepayment in January 1973. HEW assistance totaled $343,000. Successful marketing of the HMO to three large employee groups has resulted in doubling the initial enrollment in 1 year to its current 5,800 enrollees.

Michigan HMO Plan, Detroit, Mich.

The sponsorship of this plan rests with Detroit Medical Foundation—an affiliation of 50 doctors, some of whom practice in a group and others who practice as individuals. HEW assistance has totaled $300,000. With the award of a State medicaid contract for serving 40,000 title XIX beneficiaries, the HMO became operational in February 1974, and has enrolled 3,400 persons. The program plans to expand beyond the medicaid sector.

Dr. EDWARDS. I might make one other point. By my statement I did not mean to imply ther aren't some very successful HMOs around, like the Kaiser Plan, of which you are well aware.

Mr. MICHEL. There again, is it not true that that really skims the cream off the top?

Dr. EDWARDS. Yes.

Mr. MICHEL. Many people labor under a misapprehension. You cite that so many times, but it is about like comparing the United Parcel Service with the Postal Service. United Parcel Service is very successful and a moneymaking organization today because it skims the top and takes care of the real profitmaking business, and the Postal Service is taking care of the rest.

We are talking here in terms of a community or area that is capable of funding that kind of operation, whereas some economically depressed area might not be anywhere near able to do the same kind of job.

Dr. EDWARDS. That is very true. I think we will see a little faster growth in HMOs, particularly, if we get a national health insurance plan of some kind. Also the fact that we have to recognize is that 10 years ago the average practicing physician, or certainly organized medicine, would not even admit that HMOs exist. Today, they not only admit that they exist, but most of them will admit that they are a very logical and reasonable kind of service and provide good health care. That is not to say we should have all HMOs by any stretch of the imagination, but it is an accepted form of delivery of medical service.

EMERGENCY MEDICAL SERVICE

Mr. MICHEL. Turning to emergency medical services, you say that you plan to initiate and expand these services to provide State and local governments and other entities support. You also go on to say that it is not to establish a network of federally supported emergency care systems.

Why did you add that sentence or proviso in that particular paragraph? Is there some concern?

Dr. EDWARDS. We feel that if these are to be successful, they have to be locally initiated and locally funded. We look at this as a demonstration kind of program.

Mr. MICHEL. Do we still have six demonstration programs around the country, or are there more now?

Mr. BUZZELL. We have nine. Essentially, we have the same arrangement we had before.

Also, on Dr. Edwards' testimony, you may recall that the law requires that we give priority to providing assistance to the State and local governments. That is the approach we are taking. We really view this as a form of revenue-sharing, if you will, whereby we provide seed money and assist the State and local governments.

Mr. MICHEL. Have you gotten any indication at all that the States or communities will take you up on that general revenue-sharing bid?

Mr. BUZZELL. Almost without exception, although there is some misunderstanding which we are trying to correct. One of the other requirements is the one that makes this a tough decision for the State or the local community. They have to match our cash with their money. That therefore gets them into the priority determination as to how they want to budget their funds.

Generally speaking, the States have passed the laws they need to establish emergency medical service systems, and have made provisions in their budgets.

ILLINOIS EMERGENCY MEDICAL SYSTEM

Mr. **Michel.** Have you made any kind of assessment of the plan in Illinois?

Mr. **Buzzell.** The answer is, yes, sir.

Mr. **Michel.** Is it good, bad, or indifferent?

Mr. **Buzzell.** The returns are just coming in, basically. As you know, they have not completed the development of the system. We are quite impressed with the progress to date, and have so indicated. As you know, we are impressed with the performance of the individuals involved.

REGIONAL MEDICAL PROGRAMS

Mr. **Michel.** I asked the Secretary yesterday several general questions with respect to the regional medical program. With all the additional money that would be going into that program, which you say frankly ought to be phased out, I asked the Secretary whether or not we were going to be wasting our money, throwing good money after bad.

I take the Secretary at his word when he says by no means would we permit that to happen. Could you be any more specific on that, Dr. Edwards?

Dr. **Edwards.** As you know, we have an awful lot of money to spend on regional medical programs between now and next February. It is going to be a very major undertaking if we have to follow the original Congressional intent in spending this money. It will be a difficult job to spend it wisely.

Mr. **Michel.** What are some of the unwise ways that this money would be spent if the Congressional mandate were to be adhered to, to the letter of the law?

Dr. **Edwards.** Again, I think we have to recognize, good, bad, or indifferent, the fact of the matter is the regional medical programs have been phasing down over the past year. We have lost some capacity to wisely utilize these funds out in the various local regional medical programs. The regional medical programs do not have the personnel that they had a year and a half ago to wisely spend this money.

Mr. **Flood.** Of course, the reason you do not have personnel is that you told them you were going to close the joint up, and they all left.

Dr. **Edwards.** That is right. I think the rationale behind our recommending a year ago that regional medical programs be phased out was logical. That does not mean, as I said a year ago, that there are not good regional medical programs. We are spending $100 million a year, and this year it will be considerably more than that, closer to $200 million, on an assortment of programs, some good, some bad, that have little or no relevance to trying really to improve the overall health care system in this country.

I think most of the leadership around the country would agree with us that we have to make a regional medical program much more specific than we made it, or the Congress made it, back when it was originally passed.

EFFECTIVENESS OF REGIONAL MEDICAL PROGRAMS

Mr. MICHEL. I could not agree with you more. You get a bill on the floor of the House, and, first of all, you say "medical program"; and everybody says, "How can I be against it?"

Second, you say "regional"; and the guy says, "Well, this is something closer to home." I suppose if you had "statewide" they would be a little bit more eager. If it is a local one and my community of Peoria gets involved, I have to be all the more for it.

That is about how much 95 percent of the members know about the program over in the House and Senate, frankly, nothing more than a name, a "regional medical program," but no idea how it works. If it is not working and is nothing more than a name in a lot of areas, I would like you specifically to lay out in the record why it is not more than what people think it is. If it is not effective and is not doing the specific job you are attempting to do, then we ought to be able to have those arguments in hand when we get on the floor and have to fight Members who do not know two hoots in hell about what it is doing specifically, other than that it is called a regional medical program.

Give me some arguments that I might use so we might engage in a spirited debate on the floor as to whether or not there are good grants or bad grants in this program.

Dr. EDWARDS. We will be delighted to provide that.

I think the point is that when you look at regional medical programs, you have to go back in history and recognize how regional medical programs originated.

You recall Dr. De Bakey originally was the chairman of the committee that put it together, and the first name of the regional medical programs was "heart disease, cancer, and stroke," as you recall. This became a very emotional program. It became a program that was supposed to solve all the problems of the world in delivery of health care.

[The information follows:]

The initial concept of regional medical programs was to provide a vehicle by which scientific knowledge about the diagnosis and treatment of heart disease, cancer, stroke, and related diseases, could be transferred to the providers of health services and, thereby, improve the quality of care provided for those diseases. The mission of regional medical programs as originally conceived was, broadly stated, to assist the health professions and institutions of the Nation in their efforts to improve the quality of care and to organize and develop preventive, diagnostic, and treatment services directed toward the control of these categorical diseases. This original mission strongly reflected the program's origin, the President's Commission on Heart Disease, Cancer and Stroke which submitted its report in December 1964.

The first authorizing legislation (Public Law 89-239), enacted in October 1965, considerably modified the concepts contained in that report and many of its recommendations. Whereas the Commission had envisaged a linked network of specialized, treatment centers and diagnostic stations, the Public Law 89-239 embodied the concept of regional "cooperative arrangements" among providers as the principal means for achieving these results, and as a corollary mandated regional advisory groups representative of provider groups. Institutions and interests as a major voice in determining the direction, pace and scope of local programs, their priorities and activities. Information transfer, especially in the form of continuing (or career) education for physicians, nurses, and other health professionals, and the diffusion of high technology were implicitly viewed as the chief means by which the latest knowledge and advances could be transmitted from the medical centers to the larger health care system and the bedside of the patient; and this was reflected in many of the activities undertaken by RMPs in the first several years of the program.

The regional medical programs initiate and support a wide range of activities aimed at increasing the availability and accessibility of health care services, enhancing the quality of care and moderating its costs. This is done in essentially two ways: through the funding of operational projects sponsored and conducted by hospitals, health departments, medical schools, and other agencies, groups, and institutions at the regional level; and by the regional medical program staffs either directly or by working with and providing professional technical assistance to others, promoting and facilitating activities that actually are supported and carried out by other organizations locally.

Some specific examples of recent and current regional medical program activities and projects are:

> Financial and other support is being provided by the Rochester regional medical program in creating new arrangements to meet primary health care service needs in "under-doctored" rural areas in that region. These arrangements include a new physician group practice utilizing nurse practitioner in their offices; another group of physicians has opened satellite offices staffed by physicians' assistants who maintain communication with the supervising physician 30 miles distant; and assistance to a migrant health center which is demonstrating expanded roles for three nurse practitioners, which has become a community-wide group practice center.
>
> A hospital-based family health care service at Middlesex Hospital in New Brunswick, N.J., initiated in 1972 with a grant from the New Jersey regional medical program, is now providing health care to 4,000 of that city's poor. Similar hospital-based ambulatory-care programs have been started in several other cities in that State since then, again with regional medical program assistance.
>
> Continual electronic heart monitoring services comparable to those available in large urban hospitals have been introduced to Oklahoma's small community and rural hospitals as a result of a statewide coronary care monitoring network for rural areas initiated by the Oklahoma regional medical program. Forty-three monitor-equipped beds in 29 small community hospitals have been linked by special telephone lines to 10 central monitoring hospitals. Specially trained nurses in the central monitoring units help monitor remote patients, and when an abnormality is detected, confer with local staffs by telephone "hotlines."
>
> The New York metropolitan regional medical program, in cooperation with Harlem Hospital, helped establish a program for stroke management in this inner-city area. Coupling a comprehensive prevention and treatment program with a detection and information effort in the community, the project's preliminary mortality rate of those brought to the hospital suffering from stroke dropped from 48 percent to 27 percent in the first 9 months since the project's operation.
>
> A statewide network of 10 community-based health manpower consortia have been developed under the aegis of and with funding from the California regional medical program since June 1972. The central objective of this program is to more closely relate manpower training and education to the health service delivery needs in each area. The definition of such health service needs has involved participation of a wide range of health service and education institutions, such as community colleges and hospitals as well as health professionals and consumers. Initial results include greater relevancy of the training offered and elimination of certain redundant or inefficient programs.

Three points need to be made with respect to regional medical program activities and projects such as the above. First, while the spectrum of all regional medical program activities is very broad and varied, many regions have concentrated their efforts in a few programmatic areas (e.g., improved primary care in rural areas, regionalization of end-stage kidney disease treatment resources and services, more effective utilization of existing health manpower) based on locally identified priority needs.

Second; the contribution made by regional medical programs in resolving problems in such priority areas has been modest and incremental generally rather than dramatic.

Third, the concept of time limited support has always been central to regional medical programs. This concept embodies the idea of "seed money," or regional medical program investment in a specific activity only for the period of time necessary to get it begun and accepted by the community. The extent of incorporation of regional medical program funded activities within the regular local health-care financing system, therefore, has become a significant measure of regional medical program effectiveness. Thus, in 1972, for example, over 70 percent of the projects from which regional medical program funding was withdrawn, were continued under other sources of support.

Mr. MICHEL. Every Member on the floor, except those on this committee, thought this meant around the country 24 or 28 regional programs, and instead of going 1,000 or a couple of hundred miles, you could get all the care and treatment you wanted at these regional centers; but then it ended up gravitating around the existing medical centers. It just goes to prove one of the points I make, that we get so taken in on occasion by fancy names and monikers, but that alone does not get the job done.

HILL-BURTON PROGRAM

On the Hill-Burton hospital construction program, the chairman has expressed his concern. Here again, you have a popular program. Because it was popular 30 years ago, it has to be popular today.

I do not agree. Times change. Conditions change. Maybe it is time for a new Member of Congress or a Senator to have his name on a bill for an ongoing piece of legislation. We get so institutionalized.

It is natural that a Member gets up and asks the question: "We have all kinds of requests in for money from our area, and we cannot get it." Is that true today? I do not like to raise the question. How many applications have you on file? Three or four times what we are ready to appropriate, because half the applications are not worth the paper they are written on, maybe.

Dr. EDWARDS. As you know, it is a formula program. We have right at the moment close to $570 million available.

Dr. ENDICOTT. I think it would be entirely fair to say the authorizing legislation itself is obsolete. The legislation has not been substantially modified for many years. The grant programs are in five categories, which makes it very awkward for anyone to target the resources that are available to the real shortage areas. It still authorizes big chunks of money, for example, for new hospital construction.

The question came up earlier about the number of beds that we need. I do not know that report or the specific number, but it is quite clear that in the inner city, and county hospitals in big cities across the country, they have a lot of beds but the beds would not qualify under modern standards. They are obsolete. Probably a lot of those big, old monstrosities ought to be torn down. Many of them have enormous wards.

For example, you are familiar with the military hospital in New Orleans or Cook County in Chicago or Los Angeles County Hospital and New York City. They are old, obsolete, inefficient facilities. They are still caring for patients but they barely squeak by the safety codes. It is very wasteful and expensive to provide care in those facilities, but there are the beds and they are being used.

The Department is still discussing actively whether or not to propose an alternative to Hill-Burton, whether we should come forward with a new proposal in the construction area. We are sure of one thing, that the existing one is not adequate at this time.

ALTERNATIVES TO HILL-BURTON PROGRAM

Mr. Michel. I would certainly have to agree with you. Conceivably, as an alternative, to ward off criticism, I would like to encourage those of you who are responsible for coming up with an alternative to move as quickly as you possibly can.

When we have these really outdated facilities that you have cited, if we started over from scratch it would have to be new construction rather than modernization, would it not?

Dr. Endicott. I cannot give you any assurance that legislation will be forthcoming, but several alternative approaches are being examined and considered at the present time.

Mr. Michel. That is why I am saying as a Member and one who ought to have a little bit to say about stimulating my own administration to do things, that I think it would be a smart thing to do, and we ought to get off the dime if that is what we are really thinking abou seriously as a constructive alternative.

Dr. Edwards. That is exactly what Dr. Endicott's agency is doing.

Dr. Endicott. I might mention some of the alternatives that are being considered.

One is to replace the formula grant with project grants.

Another is to focus on a very limited grant program to take care of areas with very low per capita income, so low that they really do not have the resources to get into the private money market.

Mr. Michel. But it gives you a start and seed money that would generate additional money to fulfill the project.

Dr. Endicott. Those are the two major new approaches that are being used.

Dr. Edwards. Let me also point out, as I told the chairman and mentioned to you, some of the $570 million we have this year we will have available in 1975. Although the program shows a zero request, we have a carryover of about $316 million. So this program is going to be reasonably well funded through 1975. Also, we have half a billion dollars in loan funds that are available.

Mr. Miller. I think the Secretary also testified, and I think perhaps we tend to underemphasized the fact, that there is an enormous amount of support for capital expenditures for both modernization and building of hospitals coming out of both medicare and medicaid to the tune of about $790 million a year, and from the private insurance market of over $1 billion. So these are the major sources. The argument centers around the relatively small Government grant program.

MEDICAID AND MEDICARE DEPRECIATION PAYMENTS

Mr. Michel. I took that up with the Secretary yesterday because he was making the point that cranked into medicare and medicaid is the depreciation that will account for modernization. But then I came back with the key question, can you cite one instance where a hospital has used those funds for that purpose?

Mr. Miller. I don't recall but I hope he offered to do so for the record because I am sure we can.

Mr. Michel. I am not sure, but so it is in one place here I would appreciate if you would because that again is going to be the first response I get on the floor—it sounds great, sounds good, name one. I would like to be able to respond if I could.

[The information follows:]

Over the last few years there has been a general recognition and acceptance of depreciation and/or capital fund charges as a proper and reasonable increment of reimbursable health care costs. Therefore, virtually all hospitals now use third party payments to help meet their capital financing needs.

Several broader issues must be considered when addressing capital financing from third party payers. Crucial to this entire issue is the financial posture of the institution at the time a capital project is undertaken, and second, the scope of the proposed project. If we are talking in terms of using third party payments in a depreciation fund to be used to replace the facility some 30 or 40 years hence, there is no possibility—even starting from a debt free position—of recovering sufficient capital funds to totally meet the replacement needs. This is explained in that inflation and the cost of technological advancements would substantially exceed the growth of capital realized from third-party payments, even if they were prudently invested. For an institution which is faced with debt retirement, third-party payments must go toward debt retirement and would preclude the accumulation of a capital or building fund.

It may be possible for an institution in a sound financial position to undertake a modest expansion, modernization or renovation project—say adding 25 beds to a 250 bed hospital—and accommodate this financing essentially from third-party payments which would be recovered across the entire hospital operation. While this may be a practical and feasible course of action to be followed with respect to the specific project, it is done so at the expense to the replacement funding of the entire facility.

COMMUNITY MENTAL HEALTH CENTERS

Mr. Michel. On community mental health centers, that gets to be another toughy down there on the floor meeting our adversaries or contemporaries. We turn into adversaries.

How many additional communities over and above those 500 and some that we already have involved in this program have really expressed a burning desire to participate in a program like those that have already been funded here before?

Dr. Egeberg. It depends on who you listen to, sir. It is my intent, and I believe, that of the Congress that every catchment area have a community mental health center in it. This would mean approximately 1,500 to 1,600 centers.

A total of 626 centers, which is well over a third of the total, have been funded; 86 new centers will be funded this year as a result of congressional action in the fiscal year 1974 budget.

The general consensus is that they are good. Some aren't. But I think most of them have been very useful.

In this request GAO has been evaluating the programs and has made some few criticisms. But the question of the source of future funds for new starts is one of philosophy. Traditionally a State is responsible for mental health care, and I think that it was the State of California that initially demonstrated that many people in State institutions could be treated more effectively on a community basis.

I think it is the philosophy of this administration that the Federal Government has demonstrated the value of community-based care through 626 funded community mental health centers, and that the States must take the initiative for future new starts.

An additional source of funding will be through national health insurance when it is enacted. There is a study being made now to determine the amount of money that a center could receive through insurance.

To answer your question or to review what I said, well over a third of the Nation's catchment areas have been funded. A major portion of these will be in operation at the end of fiscal year 1975, and this seems sufficient to demonstrate the value of community-based mental health care.

NATIONAL HEALTH INSURANCE REIMBURSEMENT FOR MENTAL HEALTH SERVICES

Mr. MICHEL. Your feeling, having mentioned comprehensive health insurance and that proposal also including the mental health area, psychiatric area specifically, is that form of reimbursement in the insurance would then be provision enough to stimulate the State and local communities?

Dr. EGEBERG. I think the national health insurance will become an important source of funds for these community mental health centers, together with State and local funds.

Dr. EDWARDS. I think this is somewhat an aside, but I think the principle holds true in mental health service. I think if we expect the Federal Government to put community mental health service centers in every community in the United States, we can also expect them to put emergency medical systems in every community in the United States and on and on into the night. I don't think we have got that kind of capability, and that is why the Congress set up the Emergency Medical Service law as a demonstration kind of activity and not in an attempt to provide Federal emergency medical systems in every hamlet and city in the United States.

Mr. MICHEL. Of course the only problem with that is, as you well know, there are those of us fortunate enough to have a community mental health center funded a year or two ago, maybe even on this committee. Our colleagues say, and they are just finally getting revved up, "We aren't getting what you got." And we are pretty hard pressed on the floor of the House to say ours is a pilot and you do it yourself on your own.

Dr. EDWARDS. And, I might add, it is a very logical and legitimate complaint.

ALCOHOLISM TREATMENT PROGRAM IN PRIVATE INDUSTRY

Mr. MICHEL. You say in 1975 you are going to contract with profit-making institutions to organize and establish alcoholism treatment programs in private industry which can later be supported by private health insurance programs. I am a great free enterpriser and I want to just say by going this method we are going to be better off.

What assurance do we have that in this contracting business there are not going to be any unconscionable profits realized, even though I personally might very well support the private enterprise concept of doing it that way?

Dr. **Edwards.** We will obviously very closely monitor both the development of the contract and the execution of the contract like we do in other contracts. As I understand, the individual rate of return increases with the amount of third party reimbursements earned. In no case, however, will they be able to earn profits in excess of 15 percent.

Mr. **Michel.** I hope you would because I have found out in my own State what the really good private enterprise profitmaking organizations have been able to do in the field of handicapped children, particularly a job at half the cost of what the State was doing and in a much better environment all the way around. It is something we ought to take advantage of, provided, of course, it doesn't get out of hand.

Dr. **Edwards.** No, it has to be closely watched.

DRUG ABUSE

Mr. **Michel.** You say, "Although the budget request for drug abuse will drop from $243.5 million in 1974 to $216 million in 1975 we still will be able to maintain the same level of treatment capacity in 1975." I suppose if the chairman were asking the question he would ask if you do that with mirrors. I will just ask you forthrightly how can you do that?

Dr. **Edwards.** Despite the overall dollar decrease this budget will maintain 95,000 to keep all of the treatment slots in fiscal year 1975. This will be done by funding project grants totaling $17 million for 2 years from the funds available for obligation in fiscal year 1974. The budget proposes an increase of $10 million in formula grants to allow the States to assume greater responsibility for their own drug abuse programs.

Mr. **Michel.** Is there any pressure for expansion of those in numbers, Doctor?

Dr. **Egeberg.** No. We will have sufficient capacity to treat all projected demand for services.

I should like to point out an additional reason for lower treatment cost in 1975. Most of our grants provide matching Federal funds on a declining percentage basis. The Federal cost of maintaining the same number of slots therefore declines from year to year.

Dr. **Edwards.** I think that is a good point. Dr. DuPont who supports Dr. Egeberg's position is very comfortable with this budget.

Dr. **Egeberg.** Yes, he is very comfortable with it.

SUPPLY OF PHYSICIANS

Mr. **Michel.** When we get talking about the supply of doctors in this country and the conflicting views of those who say we are so many thousand short and one thing and another, I think you have pretty well pointed out, Dr. Edwards, in certain areas of the country we do have, or is the disparity part of the problem? Isn't it true, as a matter of fact, that in certain areas of the country we have an overbundance of surgeons, radiologists, and even nurses, for that matter?

Dr. **Edwards.** I don't think there is any question about it. Surgeons are in overabundance in all the major metropolitan areas of the country. You take in areas like the North Shore in Chicago, in Winnetka and Evanston doctors are more than plentiful, and all making a good living I might add. So there is no question that in certain of the specialties, and I think surgery is the prime example, the specialty is overcrowded. We have more surgeons than we need.

I think the American College of Surgons is doing a good analytical study of their own problem and will be coming up with a major recommendation.

SHORTAGES OF PHYSICIANS IN SPECIFIC FIELDS

Mr. **Michel.** Do we have any reports that show what the specific shortages are in specific fields? You mentioned the general practitioner is in short supply. Right?

Dr. **Edwards.** I think it is better to call him the primary care physician because that includes not just general practitioners but internists and other specialties as well. But the number has been going down over the past decade rather than up in spite of the fact the number of graduates is going up.

Mr. **Michel.** What can we do to narrow the disparity of the distribution in the country? Do you have any idea?

Dr. **Edwards** I think there are probably a number of approaches to this problem. First of all, I think we have got to take a look at the whole system of graduate medical education in this country. We have allowed, over the last decade or two, the proliferation of a number of graduate training programs in surgery and other specialties beyond what it should be. I think we have to take a good look at this, and I think we have to eliminate some of these programs.

I think it is a difficult problem to come to grips with unless you are going to tell people what they can and what they can't go into. I think it has to be organized on a volunteer basis by having only so many openings for certain kinds of specialty training. I think this kind of approach is what ultimately will come to grips with the problem. It is a long-range approach and is not going to happen today or tomorrow.

NEW MEDICAL SCHOOLS IN 1974

Mr. **Michel.** How many new medical schools have come into being in the last year?

Dr. **Endicott.** I think about four have actually come on line.

Mr. **Michel.** Which brings us to a total of how many?

Dr. **Endicott.** About 114 medical and additional 7 or 8 schools of osteopathy.

Could I offer a comment on the number business?

Mr. **Michel.** Yes.

Dr. **Endicott.** We are obviously playing catchup ball. Over a long period of time there were virtually no new medical schools in the face of a steady growth in population.

A little over 10 years ago, as a result largely of Federal intervention, we moved rapidly upward from about 75 medical schools to over 100 at the present.

FEDERAL SUBSIDY OF MEDICAL SCHOOLS

Mr. **Michel.** Every one of which is getting some form of Federal subsidy?

Dr. ENDICOTT. They all receive a subsidy through capitation.

At the same time we were increasing the entering places for medical students in this country, our immigration laws and regulations and the opportunities to practice here have attracted large numbers of foreign medical graduates. Last year 46 percent of all newly licensed physicians in the United States were graduated from foreign medical schools, and most of them were from Latin American schools. Only about 10 percent of foreign medical graduates are Americans who went abroad for their medical education.

If you add these two factors, the rapid growth in the number of schools here and a rather intensive immigration of foreign medical graduates, the number of physicians in the United States is going up quite rapidly. The forecast which the Secretary referred to would indicate that if present trends continue, immigration continues, and output of the schools continues we will have a question of possible oversupply around 1980 to 1985. That is not to say we have it now. But in terms of your deliberations as to whether you should authorize money for new schools, a new school that starts today will not put physicians into the active manpower pool for almost 10 years. And it is very important to bear in mind that you have a long leadtime here, and even though we probably have real shortages numerically in scattered areas of the country at the present time, it is too late. We should have done something about that 10 years ago and not today.

AVAILABILITY OF 1975 FUNDS FOR NEW MEDICAL SCHOOLS

Mr. MICHEL. We have, as you well know, in my home community of Peoria a new medical school as an adjunct to the University of Illinois. We have one in Springfield and one in Rockford, and these are all within the last couple of years. We now are getting into the construction stage. Actually, the school has been in operation for a couple of years, renting facilities from Bradley University, a State university renting facilities from a privately endowed institution, helping to play catch up ball. Now we have a whole new urban renewal in the center of the city brought about as a result of the new medical center we are going to have in the city.

How much money in this bill will actually go to help or assist new medical schools in the coming year?

Dr. ENDICOTT. I should supply that for the record.

Mr. MICHEL. Will you do that?

Dr. ENDICOTT. Yes.

[The information follows:]

The situation with respect to new medical schools is very fluid and subject to change. At present six medical schools, five of which were started in fiscal year 1973 and one in fiscal year 1974, are receiving startup assistance. The estimated costs for the continuation of this assistance in fiscal year 1975 comes to slightly under $2 million. In addition to these schools there are possibly six medical schools and one osteopathy school which may be eligible for startup assistance in fiscal year 1974. Any of these schools so qualifying would be eligible for approximately $2,700,000 budgeted for continuation of this assistance in fiscal year 1975.

In addition to startup assistance the new schools of medicine and osteopathy are also eligible for capitation, teaching facilities construction, and special project grants. The amount of funds going to them in these categories, however, cannot be determined at this time.

Mr. MICHEL. In this whole area of Federal support for health programs in this country, I think we too often lose sight of the very real and major contributions that are being made at the local and State levels.

It is too easy to dream up a completely Federal solution to a problem, and in so doing either ignore or freeze out community resources that may have offered great potential in dealing with the situation. Then, when the Federal effort trips on its own redtape we're left with a bigger problem than we had before, if only because of the expectations that have been raised in the meantime.

But, we do have a number of programs in the health area that, in theory at least, are designed to stimulate and encourage local initiative and efforts. I would like you, for the record, to give us some kind of listing of these programs with some brief summaries of how they work. Pick out the ones you think are working best and tell us about them. Then give us some idea as to where you and the administration would like to see national policy move with respect to encouragement of community effort.

Dr. EDWARDS. I welcome this opportunity to respond to your request for identification of Federal programs that encourage local initiatives and efforts along with the opportunity to suggest where I feel national policy might move with respect to encouragement of local initiatives and the identification of local resources.

A number of the current programs are responsive to local initiatives and the potential utilization of local resources. I would like to think that my door and the doors of my staff were always open to learn of ways in which we can be more responsive.

The degree to which Federal programs actually relate to State and community initiatives varies. Programs in health services and the development of health services delivery capacity may more readily respond to local initiatives and utilize local resources than programs in biomedical health research.

Many programs might serve as examples where local initiatives are being encouraged or where Federal and local resources have been linked. A few stand out both in terms of their success and may represent models of ways in which to proceed in the future:

NATIONAL HEALTH SERVICE CORPS—NHSC

Its objective is to assist underserved communities in securing medical personnel—primarily physicians and nurses—to operate a medical practice that has been organized by the community. NHSC helps to match corps members with communities, but the assignment must be mutually agreeable to the corps member and the community. NHSC pays the salary for the physician, nurse and/or dentist. Charges are collected by the community organization. The NHSC recovers reasonable costs from the projects and these collections are then deposited in the U.S. Treasury.

COMMUNITY MENTAL HEALTH CENTERS—CMHC'S

This program, which dates from 1963, was designed with a funding strategy that explicitly requires commitment of non-Federal funds, and this requirement becomes—in terms of a percentage—more significant as the project matures with the local contribution increasing from an initial 30 percent to 85 percent in the 8th year—in "poverty" area, the local burden is reduced; initially it is 10 percent, increasing to 30 percent. These Federal staffing grants serve as a catalyst both for state, local, and private funds. As a demonstration of what can be done, this program has been quite successful.

ALCOHOLISM COMMUNITY SERVICE PROGRAMS

This program has also stimulated and encouraged local initiative and community participation. These community service projects are marked by substantial involvement of hundreds of local citizenry in their planning, development and implementation. The programs are designed to assist communities to develop new and/or expanded services at the local level to a variety of alcoholic persons in need.

City and county governments, some of whom administer these programs, have shown an important and continuing interest in supporting these efforts through financial commitments, representation on policymaking boards of the programs, and assistance in developing local citizens groups that will support the programs.

Throughout the planning, implementation and evaluation of the community services programs, the involvement and active working support has been sought and obtained from Alcoholics Anonymous members and other volunteer groups.

Formula grant programs are inherently designed to respond to the varied needs of the several States and communities comprising them. The administration's intent with respect to a desirable national policy on the issue of State and local initiative and priority setting is clearly reflected in its efforts to encourage the revenue-sharing concept both as a general objective as well as for special purposes such as health. Two formula grant programs are particularly worth noting.

BLOCK GRANTS (314d)

This section of the Public Health Act provides block grants to States. They are, in turn, shared with local jurisdictions to spend consistent with State and local priorities. For fiscal year 1975 the administration is requesting $90 million. It would be used for purposes of public health—including mental health—as determined by States or local jurisdictions, provided that 70 percent of the funds allotted shall be available for the provision of health services in communities of the State.

ALCOHOLISM FORMULA GRANTS

Under the State alcoholism formula grant program, block grants are awarded to each designated State alcoholism agency to develop and implement a State plan for comprehensive alcoholism prevention, treatment, and rehabilitation program. Each State agency has an advisory council that is broadly representative of the socioeconomic, ethnic, and cultural groups throughout the State; these councils provide considerable input regarding local needs.

Nearly all State agencies are utilizing a regional system whereby formula grant funds are allotted to the regions on the basis of a regional plan or grant application developed by the people within th region to meet their local needs as they determine. Many of these substate regions have their own advisory councils made up of local citizens.

HEALTH RESOURCES PLANNING PROPOSAL

The administration's proposed health resources planning program would create regional boards and Statewide coordinating councils, both of which will have considerable voice in determining policies and activities for health resource development.

The regional boards are to represent consumers, government, providers, health education institutions, and third-party payors. Each regional board is to develop a comprehensive health plan to meet the health needs of all residents of its geographic area for health care systems, including facilites, services and human resources. The plan must include long-range goals and yearly priorities for specific actions in both the public and private sectors of the health market. The various regional boards in a State coordinate their plans and actions with those of related organizations through a Statewide health coordinating council, comprised of members selected from the State's regional boards. Most importantly, in terms of your question, local applications for Federal resources would have to be reviewed by the regional board for consistency with the regional plan.

The administration intends to be as sensitive as possible to local needs and local conditions insofar as they give rise to unique opportunities or pose special constraints.

The "working partnership" to which I made reference in my testimony and about which there was a question from Representative Shriver—and to which I have responded—is intended as one means of keeping abreast of State and local concerns. This partnership represents an ideologically "open door" both while we are developing policies and with respect to current policies. We feel that this broad partnership together with increased decentralization of our programs are useful ways for us to proceed with respect to the encouragement of community effort and staying abreast of contributions they can and should make.

Clearly, the Federal role in health programs has been shifting. Over the past few years the administration has been developing programs and policies that will enhance consumer purchasing power for health services—an explicit objective and anticipated consequence of the proposed comprehensive health insurance plan. And it has been encouraging existing institutions to develop capacities to capture alternative resources, particularly through "third party" reimbursements. Rather than expanding its direct role in the provision of health services, the administration wishes to encourage the development of and building upon State and local resources in terms of facilities, staffing, and their management.

Mr. MICHEL. That is all.

Mr. FLOOD. Mr. Smith.

FOREIGN MEDICAL GRADUATES

Mr. SMITH. Those are interesting statistics. I have been thinking we have been depending on foreign sources for 38 percent of our oil and now it is 46 percent of doctors. It doesn't comfort me very much to think that we are going to incorporate into our policies and our thinking continued dependence upon that kind of a source. Any time they want, a country can prevent those doctors from coming over here even though our immigration laws permit it.

Dr. Endicott. For the past 4 or 5 years we have had a bulge in the number of foreign medical graduates entering the country. Probably the normal figure, one that we can expect to continue almost indefinitely, would be on the order of 2,500 to 3,000 physicians who migrate to this country.

Mr. Smith. What percentage do you anticipate that will be by 1980?

Dr. Endicott. By 1980 we will surely be graduating 15,000 physicians here. So it would drop back as one would expect to 2,500 or 3,000.

Mr. Smith. You are talking about 20 or 30 percent now.

Dr. Endicott. Right.

Mr. Smith. Do you think it will drop from 46 percent down to 20 or 30 percent?

Dr. Endicott. No.

Dr. Edwards. I don't think that figure of 46 percent is an accurate figure in terms of total number of doctors in this country who are foreign trained.

He was using the number of licenses in 1 year and not the total number in practicing the profession.

Mr. Smith. It seems to me in trying to determine what our policy should be we should not incorporate a dependence upon large numbers of foreign nationals coming in here. These are good jobs. We have people that want to enroll in these medical schools. I don't think we should incorporate into our permanent policy a policy of that proportion of immigration of doctors.

Dr. Endicott. Our long-term projections are based on two assumptions: 2,500, 3,500 a year, both of which are very substantially below the present immigration.

There are a variety of reasons why doctors come to this country. We expect they will probably continue to do so but at a much lower level than they are now.

There is another factor which was not mentioned which I presume I will cover when I appear myself on the budget.

There is clearly a move on the part of the national bodies which authorize and approve training and residency slots in this country, to reduce the number of authorized residencies in the United States. We now have about 15,000 approved but unfilled so-called residency positions in hospitals. The profession has a newly established organization, the Coordinating Committee on Medical Education, which has representation from the medical societies, the hospital association, the Association of Medical Colleges and so on.

I anticipate on the basis of our interactions with this newly established organization that the number of approved slots will be cut back especially in areas of surgery. At the same time, because the number of graduates competing for these slots is steadily increasing, the opportunity for foreign medical graduates to come to this country and get their nose under the tent as trainees or residents will be substantially diminished.

Dr. Edwards. To add one other thing, we are also working with other groups to reassess the so-called ECMG, the examination that these foreign students take before they can become qualified to enter the United States and get into training programs. We are reevaluating that, and I think without any question within the next year or so we will considerably stiffen that examination which will eliminate a very sizable number of foreign medical students.

Mr. SMITH. So you mean the examination they take now is not as stiff as the one they take if they come from American schools?

Dr. EDWARDS. Oh, no. They have an examination—I have forgotten exactly—in which they have to have a passing score of 70, and as I recall only about 30 percent of the total that take it eventually pass it. Am I correct?

Dr. ENDICOTT. About 50 percent. It is the ECMG examination and it is given overseas. Our hospitals require that they pass this examination with a score of 70 before they are eligible to enter the country.

Dr. EDWARDS. They can take it as many times as they want.

Dr. ENDICOTT. The questions that are selected for this examination which only half of them pass are questions which 95 percent of our graduates would pass.

Mr. Smith. But do the ones who are educated in other countries and practice here have the same qualifications as the ones who graduate from American schools?

Dr. ENDICOTT. It is a very interesting situation. Our graduates do not take an examination for a residency.

Dr. EDWARDS. But more and more of them are taking national board examinations which would be equivalent, only much more difficult. It is in three parts.

Mr. SMITH. Are you saying that some of these doctors who come in from other countries could not qualify if they had graduated in this country?

Dr. EDWARDS. I don't think there is any question about it.

Mr. SMITH. They could not?

Dr. EDWARDS. They could not.

LICENSING OF FOREIGN MEDICAL GRADUATES

Mr. SMITH. Is it the State medical boards that are permitting them to practice?

Dr. EDWARDS. Ultimately when they get their State license they have to pass a State board. But the point is that they can come into the training programs being far less qualified than the average American.

Mr. SMITH. By the time they start to practice medicine——

Dr. EDWARDS. By the time they start to practice medicine they have to pass board examinations, but they don't practice before. Many of them are practicing in hospitals as residents and interns.

Dr. ENDICOTT. They are not required to have State licenses to be an intern or resident.

Mr. SMITH. Doing institutional work?

Dr. ENDICOTT. Right.

ACCESS TO CARE BY RURAL COMMUNITIES

Mr. SMITH. In the 16 years I have been here we have spent billions and billions for biomedical research. When I first came here it was a very small amount, and it has gone up and up. But we still have a substantial area of the country that just simply hasn't benefited very much, other than perhaps a little on their deathbed, from the great results that we have obtained.

I am talking now especially about the more rural areas where people live in communities of 300, 500, 700, or 800 that just simply are not within reach of medical service. Many of them are elderly, some of them haven't seen a doctor for 10 years. HMOs will not reach them. What do we have on the horizon that is going to reach this kind of people?

Dr. EDWARDS. I think unfortunately we don't have enough on the horizon. We have one small program we feel is very successful and believe can be made much more successful. That is our National Health Service Corps which we are enthusiastic about, and at the present time I think we are in 183 communities and will be expanding in the 1975 budget. This isn't satisfying the problem, but it is a step in the right direction. We are hopeful that our scholarship program, which we are taking from $3 million to $22 or $23 million in 1975, with service obligations connected with it, will have some impact in terms of satisfying some of these needs.

Mr. SMITH. That hasn't worked where it has been tried, has it? The Sears plan didn't work, did it?

Dr. EDWARDS. No. The Sears plan, though, was a little bit different.

DISTRIBUTION OF PHYSICIAN MANPOWER

Mr. SMITH. I don't have much hope that you can bribe some doctor for a couple of thousand dollars a year when he is making $50,000 to $60,000 to get him to live where his wife doesn't want him to live.

Dr. EDWARDS. No question. In 90 percent of the cases you are 100 percent right. Fortunately there are a few that will help fill some of the need, but it isn't going to solve the problem.

Mr. SMITH. It takes some kind of a change in the delivery system and I don't know what we are going to do unless we have allied medical professionals or perhaps nurses, with some special training, working under a doctor. They could perform some local reviewing or something for the doctor. But in this budget you are moving towards less for nurses. They are even getting reduced a bigger percentage than other medical personnel. So how do you propose to move toward helping this kind of people?

Dr. EDWARDS. I think I would answer your question in two ways. I think your basic premise is 100 percent right. I don't think we are ever going to get enough doctors to get out in the rural areas.

Mr. SMITH. To have enough doctors so one would locate in every one of those communities would require a tremendous surplus. Some would be driving cabs in the cities.

Dr. EDWARDS. We would have the same problem they have in the Philippines. So it is going to require better utilization of allied health professionals, better utilization of certain kinds of transportation, and better utilization of information exchange.

There is a lot going on in all of these areas. We feel the capitation per se is not going to have a significant impact in terms of the numbers of nurses we are talking about.

I think more important than that is better to define the role we want the nurses to play in these rural health systems, which we never really have done. I think by upgrading their status in the health delivery system and better defining the status of the allied health professions——

Mr. Smith. How will you get that done?

Dr. Edwards. There are not enough, but there are some demonstration programs around the country, here and there.

UTILIZATION OF ALLIED HEALTH PROFESSIONS

Mr. Smith. I think it already has been demonstrated that it will work. If the Medical Practice Act rules and regulations will not permit a nurse to legally prescribe an aspirin, which is the case in Iowa, they cannot really use their professional ability except while the doctor is looking over their shoulder. What incentive is there for them to take this extra training?

Dr. Edwards. I think you have really answered your own question. I think before we can expect these kinds of programs that you are looking for and that we are looking for really proliferate and do the job that needs to be done in providing health services, we have to come to grips with some of the licensure problems and some of the definitional problems.

A lot of it has to be done, not by the Federal Government, but by States and also by the private sector.

LICENSURE PROBLEMS

Mr. Smith. There is no question the States could do it if they would. That brings us to my next question: What are you doing to encourage the States? Next week, if they wanted to, in Iowa the appropriate boards could meet and change those rules. They have been talking about it for 5 years, but I do not think they have done a thing of any significance.

What can you do? You surely can do something to encourage them to make these changes.

Dr. Edwards. I think we have done far too little. I think we have relied too much on groups like the AMA and AMC to solve these problems for us, and they have not solved them.

AVAILABILITY OF ADDITIONAL MEDICAL SERVICES

Mr. Smith. On top of this kind of system, we are talking about an infusion of billions of dollars of additional money. All that does is distribute more money under the same system, just inflating the cost. I do not see where we get the additional medical services.

Dr. Edwards. I am concerned that if we had to implement a national health insurance program tomorrow morning, we would need to put a lot of things in place before we could move forward.

Mr. Smith. Otherwise there would be tremendous inflation in cost.

Dr. Edwards. I think the only salvation, certainly in the plan we are proposing, is that the implementation is 2 or 3 or 4 years away. I am not sure that is not horribly optimistic.

Mr. Smith. The truck drivers blocked the Pennsylvania Turnpike to get action at the top level. If we have a strike somewhere that affects the mass transit system, if necessary even the President gets involved. He gets them in a room and gets them talking to one another to come up with a solution.

But, somehow, this lack of health care situation goes on and on. It seems to me somebody could get these people together.

Dr. EDWARDS. It could be the pressure groups do not want it to happen.

Mr. SMITH. I am sure they do not. My point is that Government does take action in other fields.

Dr. EDWARDS. Your point is well taken.

Mr. SMITH. They could get the hospital people and the different medical people together, and surely they could come up with some kind of solution that would make some progress, perhaps a model for the States, and then encourage them to take at least one step.

Dr. EDWARDS. I am not quite as optimistic as you are. I have been dealing with them now for the last 10 or 12 or 13 years. I cannot tell you the number of meetings I have sat in with the appropriate groups. Somebody has to begin to bang the heads together and say this is the way it has to be done, and move in and do it.

NATIONAL LICENSING

Mr. SMITH. Perhaps the added encouragement is the threat of national licensing.

Dr. EDWARDS. Yes; and renewal of licensure, and a few things like that.

Mr. SMITH. I sympathize with a lot of what you have said here. It seems your are trying to look ahead for several years to come. HMOs, I know, will not serve the area I am talking about. It seems to me we are leaving out of our forward planning a big percentage of the people in this country who need the medical service the worst, they have even less services available than the indigents in the city. They have more service available right now than this 30 percent has out in the rural areas.

Dr. ENDICOTT. I think one of the really encouraging signs of the times is the current development in a few States, which is just beginning to catch on, of an improved administrative structure within the States to address the problem of health service. The activities of the board of medical licensure of the State medical school, and all of the resources that are under the control of the State can be brought more effectively to bear to address the problem of the delivery of health services.

I might mention two States which have been pioneering in this area at the present time. One is the State of Wisconsin, and the other is the State of South Carolina. The Governors of the two States have put a top priority on doing something about delivery of health services.

They have created State health commissions which pull together all sorts of things within the State. They are remodeling the residency program, the State licensure plan, the college level plans for training middle level health workers, and developing and implementing a purposeful State effort in this direction.

I am optimistic that the comprehensive health planning proposal which we have put forward, and which we will be discussing in terms of the supplemental budget later on, offers the first real hope I have seen to attack this problem.

I do not think individual practitioners are going to go out there. I think they will have to be part of a larger organization.

Mr. OBEY. Doctor, I wonder if for the record you would mind expanding a little bit about exactly what is happening. I think Wisconsin's Governor is going in the right direction. I would like it specified for the record.

Dr. ENDICOTT. Yes, sir, I will do that.

[The information follows:]

The Department of Health, Education, and Welfare is working on two fronts to strengthen planning efforts in this country. The first is in terms of the currently operating comprehensive health planning program and the second is through administration's legislative proposal for health resources planning.

With regard to strengthening the ongoing program, we have set forth several major program activities. These include:

(1) *The enunciation of program priorities*

Purpose: These priorities include cost control through improved efficiency and productivity; minimizing uneconomical duplication of facilities and specialized services; and more effective competition within the pluralistc health care system in order to improve consumer choice in the organization, financing, and delivery of health servics.

(2) *Development and implementation of performance standards for State and areawide CHP agencies*

Purpose: To define the role and responsibilities of 314 (a) and (b) agencies and the standards in functional areas that they are expected to meet. These performance standards will serve as criteria against which an agency's performance will be judged in the national assessment program.

(3) *Assessment of all planning agencies and assisting with corrective action*

Purpose: To determine the capacity of existing agencies to meet the above-mentioned performance standards. Consolidations, expansions of planning areas, or terminations of agencies may result.

(4) *Provision of technical assistance to State and areawide agencies*

Purpose: To increase the performance of health planning agencies by providing technical guidance to agency staffs and councils.

(5) *Implementation of section 1122 of the Social Security Act, as amended*

Purpose: To establish a working system of facilities and services review that will assist State and areawide agencies in fulfilling their responsibilities under section 1122.

(6) *Improvement of the technology of health planning*

Purpose: To develop new methodologies to assist CHP agencies in fulfilling their planning responsibilities.

Our efforts to upgrade future planning activities are set forth in the proposed legislation, "health resources planning bill," which was introduced as S. 3166 and H.R. 13472. In this bill, we have taken steps to build on current experience both at the State and regional level.

At the regional level, we propose to establish health systems agencies which would have several specified functions. They include:

(1) The development of a comprehensive health plan to meet the health needs of all residents of the geographic area, including facilities, services, and manpower. In this plan priority would be given to identifying the most acute shortages, maldistributions, and surpluses of health personnel, facilities, and services, and the most serious existing health service delivery deficiencies in the area. The plan would recommend actions by appropriate individuals and organizations in each sector of the health care system to alleviate those problems. Agency activities would also be open to the full participation of the public.

(2) Advising governmental regulatory bodies on matters such as proposed capital expenditures under section 1122 of the Social Security Act and in areas such as licensing of health manpower.

(3) Reviewing Federal grants providing support for capital investments, developing health services or training health manpower.

(4) Assisting the Department of Health, Education, and Welfare by planning and providing technical assistance to develop grant proposals for Federal assistance and providing technical assistance to grant recipients.

(5) Conducting evealuations and analyses concerning health manpower, facilities and services, costs and financing of health resources, and the health status and needs of its geographic area.

(6) The Health Systems Agency would be authorized to provide technical assistance, by, grant or contract, to implement any action recommended in its comprehensive plan.

To assist the agencies in fulfilling these responsibilities, the Secretary would make a grant to be used in meeting the expenses of operation. There would be no matching requirement so that agency personnel could concentrate on carrying out the specified activities as opposed to devoting substantial time and effort to fundraising. Furthermore, the Department would be required to assist each agency in performing its functions by providing the agency with materials pertinent to health care planning methodologies, health care system studies, research and related information available, including information pertinent to health care resources and utilization. The materials provided would include model curriculums, and other information on the health care system, that would further educate members of the agency.

With regard to the State level, we propose to make this the locus for regulatory efforts. To stress the development of this role, the Secretary would be authorized to make grants to support State efforts to regulate the reimbursement for health services and the extent of capital investment in the health care system. The grants would be on the basis of a State's population and the costs of performing the functions. If the State chooses to administer both regulatory functions through one agency, that State would be eligible for a bonus payment of 25 percent of its Federal payment for that year. To insure that there is an integrated relationship between the State's regulatory activities and the planning responsibilities of the Regional Health System's Agencies, the State would first obtain the recommendation of the Health Systems Agency with respect to any capital expenditure within the Agency's health service area. If the State takes action contrary to that recommendation, there must be a procedure under which its decision is reviewed by the chief executive officer of the State or his designee.

Mr. SMITH. I know a young man talked to me about 2 weeks ago who was unable to get into medical school. That did not seem to bother him as much as it would me. He had planned all his life to go to medical school, and he could not go.

What really bothered him—and he had a right to be bothered—is that there is really no other kind of school he can go to, an allied school of some kind, with assurance that when he gets out he can really use his training.

Dr. EDWARDS. That is a real problem.

Mr. SMITH. If you do not know that you can use what you are going to school to learn, who will go to school?

Dr. EDWARDS. In spite of the fact I think these are brighter days than a few years ago, I would not want us to leave in your mind or make you believe that we believe this problem is about to be solved, because it is not. There is still a lot of foot dragging.

The bulk of the States are not yet involved in this in a meaningful way. Wisconsin is far out in front, as are several other States.

Mr. SMITH. I am fairly patient, I think. I promoted a meat inspection law for 9 years before it passed, and three or four others for long periods before they were passed.

I remember that 5 years ago Secretary Richardson came in and we talked about something similar to this. I thought something was going to be done faster than he left the Attorney General's chair, but nothing has been done yet.

Then each new Secretary that comes on has talked about it, but they do not ever get down to where something is really done.

I think surely at the highest levels of the U.S. Government some kind of persuasion could be exercised to get State societies to see that they have to move, because if they do not we will have laws passed which will put things in a worse mess than they are now.

The committee will recess until 10 o'clock tomorrow morning.

Mr. **Flood**. The committee will come to order.

Mr. Obey.

Mr. **Obey**. Thank you, Mr. Chairman.

MEDICAID AND MEDICARE DEPRECIATION PAYMENTS

Doctor, a question on Hill-Burton. In your statement you said that Hill-Burton had been successful, that the Nation had adequate supply of hospital beds, and that we are now moving into an era where virtually all medical care would be funded through some type of insurance plans which would include compensation and depreciation of facilities.

Can you tell me to what extent, if at all, is medicare paying depreciation on facilities constructed with Hill-Burton funds?

Dr. **Edwards**. According to our estimates, reading from the document that I have here, these reimbursements will amount to about $0.8 billion for medicare and medicaid and about $1 billion from private insurance.

Mr. **Obey**. The reason I bring that up is because of Mr. Smith's discussion with you yesterday when he was talking about the problem in developing some different kind of health care in rural areas.

We have a problem in the northern area of my State right now, for instance, where we have very large counties in terms of geography with population of maybe 8,000, 10,000, or 12,000 at most. You have a number of hospitals 35 or 45 miles away but nothing really in the whole area.

I don't know what the answer is. I wondered if you had any comments on it. It seems to me with medicare paying for this depreciation in effect people are paying twice. The first time when the hospital is built they have to meet certain requirements in terms of defined need, but if they are going to be rebuilding a hospital 20 or 30 or 40 years from now, who is to determine then whether or not that is a good place to rebuild a hospital or whether population shifts occurred sufficiently to warrant that hospital going someplace else? How do we handle that in terms of long-range planning?

Dr. **Edwards**. Let me first say, when I made the remarks that I thought Hill-Burton had been successful, it has in a general way been successful. But we have to recognize that through Hill-Burton we have built a lot of small hospitals around the Nation that haven't accomplished what we had hoped they would accomplish. So I wouldn't want to leave the idea that I thought Hill-Burton had been a complete success. We probably channeled money into hospitals where we would have been better off with larger hospitals more strategically located geographically.

Nevertheless, in our discussion with Congressman Smith yesterday he certainly outlined the real issues as they relate to trying to get health care into the rural areas. As a matter of fact apropos of that discussion we had a discussion in my office this morning trying to figure out how we could pull the appropriate health groups together and literally give them an edict to either come up with a planning system or we would submit to the Congress a plan for the Federal Government to do it.

We have recently done this, as you probably remember. Some time ago we laid out a new Federal strategy for a national blood program. We went to the private sector and said:

> You have a chance to implement a national blood program. We are giving you this opportunity. If you don't, then we will go to the Congress and ask the Congress to take appropriate steps.

I won't at this time say we have necessarily accomplished that in its totality, but we certainly have gotten the appropriate groups together. They have submitted a plan which we have recently put in the Federal Register for comment, and the same kind of strategy could be used as it relates to convening the appropriate groups and giving them the message that either they come up with a plan that can be implemented or we are going to have to develop some kind of a Federal program and work it that way. We just haven't done it up to this point in time. We have small programs as we move along.

Mr. MILLER. If I could add a word, this simply indicates that you cited a problem Hill-Burton won't solve and doesn't go any closer to the solution.

LOCATION OF NEW HOSPITALS

Mr. OBEY. My question is this: I see hospitals now being rebuilt just because that is where they located 20 years before. They have no business being built there these days. Because of the population shift they ought to be someplace else.

Mr. MILLER. Using the formula grant approach we just can't solve the problems people are citing these days in the inner city and in rural areas. If there is a Federal role in hospital construction, and I am not sure whether there is or isn't other than support through medicare, it is certainly going to have to be a targeted role and not a formula grant role. I think that is the area we are exploring and possibly the Congress should be.

Mr. OBEY. I don't have the answer to it, but when medicare pays in part for that depreciation fund it in fact is making it somewhat more likely, it seems to me, those hospitals are going to be rebuilt in the same place. I don't know how to get at it.

Dr. EDWARDS. That is right. The legislation that is now being considered on comprehensive health planning, both the bill that has been submitted by the administration and the bill that has been put together by Congressman Rogers and Congressman Roy, hopefully will give us a greater ability to get at this exact problem you are talking about. But certainly with a formula grant that is controlled by the States we have very little input as to where these hospitals are being located.

HEW POLICY ON DRUG REIMBURSEMENT

Mr. OBEY. Let me question you on HEW policy on drug reimbursements. You told the Senate subcommittee on February 1 that HEW intends:

> To make certain that drugs purchased under federally aided health programs are paid for at the lowest cost consistent with the need of the patient and compatible with the continued viability of the drug manufacturing and marketing industry.

You also said this effort hinges on whether the issues of the drug quality and price determination either have been or can be resolved.

As of today what is your timetable for regulations to implement that policy which I think is a good one?

Dr. EDWARDS. About 2 weeks ago we sent a letter to a number of appropriate groups that were interested in this particular subject, both consumer groups and industry groups, asking them a number of questions that we feel are pertinent to the development of this kind of a pricing policy. We have asked them to respond no later than March 30. We will quickly look over the responses and see how they relate to the strategy we have already set up. We will publish this in the Federal Register for comment sometime during the month of April. We will allow 30 days' comment, and then publish the final regulation.

Mr. OBEY. What is your estimate of the savings to be gained from this in fiscal 1975?

Dr. EDWARDS. We estimate that we could potentially save between 7 and 8 percent of the total drug bill that is being paid for by medicare, medicaid, and our maternal and child health programs.

Mr. OBEY. Why is your estimate lower than Mr. Weinberger's?

Dr. EDWARDS. I thought it was about the same.

Mr. OBEY. He said it would be at least 10 percent.

Dr. EDWARDS. Let me say between 7 and 10 percent. Our people come up with just a little lower estimate than that, between 7 and 8 percent. I would have to review the figures to tell you where we may have some disagreement.

The problem, though, is that this pricing issue is far more complicated than even we had originally thought, and that is why we have taken some time to really investigate it.

Of course we also want to avoid setting up an administrative bureaucracy that is going to cost us more than we are going to save in the purchase of the drugs. In other words, we have got to set something up that will provide this in the simplest way possible.

Mr. OBEY. Two weeks ago you told Senator Nelson's committee the physicians would be "required to give a written medical justification if they prescribed a high-priced brand name product for medicare and medicaid products." Could you explain how that would work.

Dr. EDWARDS. We haven't finalized this. It is important to point out that we are not necessarily going to demand that the lowest priced drug be purchased, but rather the lowest priced generally available drug. If a physician for some reason or other believes that his particular patient can't use that drug and has to take another drug, he will submit to an appropriate body a note indicating such. We will review these retrospectively. The number of physicians doing this will be very small, and I don't think it will be a major problem. If it becomes a major problem and we are getting a lot of these exceptions we will have to do it prospectively. In other words, the physician would have to indicate to the appropriate group he wanted to use this kind of a drug before it was actually dispensed to the patient.

DEVELOPMENT OF A FORMULARY

Mr. OBEY. Will you be putting together any kind of a formulary?

Dr. EDWARDS. We have no specific plans for a formulary. As you know it has been discussed on numerous occasions by a number of people.

Mr. OBEY. You would have to have something it seems——

Dr. EDWARDS. Of course the FDA is putting together the drug compendium, but that is not a formulary. The formulary approach may be the only way we can get at this pricing problem. I think that is a little way off.

Mr. OBEY. How far off?

Dr. EDWARDS. I don't know that we will need it. There is no reason to have a formulary if we can come up with a system that will allow us to determine the purchase price of a drug without actually going to a formulary per se.

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Mr. OBEY. Let me ask you some questions on NIOSH.

As I understand it there are enforceable Federal standards to protect workers' health for only 450 of the estimated 15,000 chemical and physical agents to which workers are exposed. That is a pretty low percentage. As I understand it you are asking for 40 new positions this year for NIOSH but that really represents only a restoration of 40 of the 95 which were cut 2 years ago.

In light of the tremendous backlog you have in establishing standards of some kind, how can you defend a budget which is that low?

Dr. EDWARDS. I would like to have Dr. Sencer speak to this if I may. But I would just say if we are going to attempt to provide standards for all chemicals, et cetera, that are used in industry, it would require a budget the size of which I don't think any of us could accept.

Mr. OBEY. I am not asking for all of them. It seems to me you have significantly lowered your sights as far as the output that NIOSH ought to be providing.

Dr. SENCER. Mr. Obey, even if we have double the number of people we couldn't significantly increase in any short period of time the number of standards that are promulgated.

Mr. OBEY. I understand that. That is why I am suggesting you are really dragging your feet.

Dr. SENCER. We are working with the Department of Labor on a new approach to go along with the criteria documentation on standards set. We have transmitted to the Department of Labor 16 criteria documents. These range from things as complicated as asbestos to benzene, noise, silica, a large number of things. We have selected these on the basis of the severity of the disease that would be caused by the compound and the size of the population that is being occupationally exposed to the compounds.

For example, asbestos, as you know, is an occupational cause of cancer, and was the first standard that we promulgated to the Department of Labor. This will protect something like 200,000 workers.

We are working now with the Department of Labor on a more rapid method of improving the protection in the workplace for those things we know to be toxic. These will not be as complicated as the criteria documents that we presently are providing but will set threshold limits, and enforceable limits that the Department of Labor can use more quickly.

Mr. OBEY. I understand, but when Mr. Stender from OSHA was here, he made it clear the input they got from NIOSH was by far the most important input they got. When I asked him why they were doing such a slow job, he said, "This takes time, it is a very time-consuming operation."

I will quote.

> **Mr. Obey.** What you are saying in effect then is that, given the input that you get from other outside sources, including NIOSH, this is about the most that you can usefully use?
>
> **Mr. Stender.** I think we are addressing them just about as fast as we can get them and as we get the solid information behind them.
>
> **Mr. Obey.** My concern in looking at those figures leads me to believe somebody is not moving as fast as they ought to. If it does not imply that your budget is inadequate in this area, I would think it would imply that the budget for somebody like NIOSH is entirely inadequate.
>
> **Mr. Stender.** It seems to me I saw somewhere where the NIOSH budget was cut back. I regret that. It is not in ours, but I thought somewhere there is a cutback on that. I do not understand that at all.

Doctor, I don't understand it either.

Dr. Sencer. There is no cutback in the program activities that we are talking about.

Mr. Obey. I understand you have that one-shot item. I understand that when we are talking about dollars. But in numbers of people you are talking about a reduction. You have 40 in your budget over last year but last year it was cut by 90.

Dr. Sencer. We cut out some of the activities we were doing last year, particularly in the area of training, Mr. Obey, so that the people that were reduced last year are not necessarily people working on criteria documentation. We protected this area of work at the expense of other things.

OUTPUT OF CRITERIA DOCUMENTS

Mr. Obey. Your budget this year proposes than you can finish how many criteria packages?

Dr. Sencer. We will finish 11 criteria documents this year and 14 next year, but this will be augmented by some 40 good manufacturing practices for workers that will be jointly developed with the Department of Labor.

Mr. Obey. Which is still something else. That is not a standard for chemicals.

Dr. Sencer. But it is much better than anything we have at the present time.

Mr. Obey. I understand that. You seem to feel that is adequate. Let me quote from a letter of Secretary Richardson to Senator Magnuson received July 25, 1972. Mr. Richardson, while he was objecting to some of the budget increases that had been made in the Labor-HEW bill stated as follows:

> There is, however, one exception which I particularly want to bring to your attention, the appropriation for the occupational and safety activities of the Health Services and Mental Health Administration. Since that budget was submitted I have become very concerned about the rate at which new health and safety standards are bing promulgated. We have so far only recommended five such standards.

He goes on to say:

> The budget estimate was built on the assumption we would recommend 20 to 30 additional standards in fiscal year 1973. I now feel we should accelerate this pace to 40 to 60 standards.

Why are you now satisfied with the much lower number?

Dr. SENCER. It is not that we are satisfied with them, but I think it is just the time it takes to develop some of these standards with the research that has to go into it. We feel we can protect more workers by concentrating on those things of highest toxicity and at the same time working on the other program I was describing to improve in general.

ADEQUACY OF NIOSH BUDGET

Mr. OBEY. The Director of NIOSH doesn't seem to agree with you. He is quoted in the New York Times:

> NIOSH is not expanding, it is shrinking. It is getting the proverbial meat ax. Our present laboratory space isn't even adequate for any kind of research. It is substandard. We have been frozen on hirings for most of our existence, and we are losing key staff right and left because we don't have the grade point to promote them. I don't think NIOSH is a viable organization at this time.

The article then stated Dr. Key had said in a later response things were still the same.

"Dr. Key said the situation hasn't improved. If anything, it is worse," the article says.

Dr. SENCER. I can't vouch for what Dr. Key said. He told me this was a comment he made a year ago at the National Advisory Council on Occupational Safety and Health and he feels things have improved now. I wish he were here.

Mr. OBEY. Will he be testifying here?

Dr. SENCER. Yes. We do have a request for space in Cincinnati to build a new laboratory; we have the design on contract. So we are moving to provide new laboratory space for the National Institute of Occupational Safety and Health.

Mr. OBEY. What additional positions and funds are being recommended in light of the vinyl chloride episode?

Dr. SENCER. We are looking at the espisode to see what needs to be done. We are not making any recommendations for additional funds or positions at this time. If necessary, we will divert them from other activities to work on this problem.

Mr. OBEY. If you do, what other research areas would be hurt?

Dr. SENCER. I don't think it is research, it is a question of how you develop the control methodology.

Mr. OBEY. Which of those areas would be hurt?

Dr. SENCER. As we approach any problem we will establish our priorities. It may be that we will pay less attention to something in infectious diseases in order to bring about corrective action here.

Mr. OBEY. Do you think that is better than asking for more money? How much did NIOSH ask for; how many new positions?

Dr. SENCER. NIOSH asked for 135 new positions in fiscal year 1975. The 1975 request to Congress is for 40 positions.

Mr. OBEY. Where up the line was it cut?

Dr. EDWARDS. I would have to go back and look at the record. The Department had to look at total manpower needs. And obviously the OMB was involved. We would have to check the record to see exactly where the cut was made.

Mr. OBEY. I frankly think you are a much better man than this budget on NIOSH would indicate, and I would like to get your answers.

Dr. **Edwards**. We have had a difficult time—there is no question about it—in terms of our whole manpower situation. And understandably the rate at which the manpower of the Department of Health, Education, and Welfare is growing we have had to live within the Departmentwide manpower ceilings.

Mr. **Obey**. Over the last 3 years.

Mr. **Miller**. Let me put in the record what we said we would put in the record for the Secretary on that. I want to make the point because it refers to Secretary Richardson's letter which was the point at which we did endorse the growth of NIOSH. In 1970 we were at $10.4 million and the 1975 request is $27.9 million.

Mr. **Obey**. I am talking about positions.

Mr. **Miller**. I think, as Dr. Sencer has indicated, there has been significant growth in positions centered on the development criteria.

Mr. **Obey**. The fact is you don't define progress in terms of numbers. It seems to me you define progress in terms of the number of criteria packages which are being drawn up, and by your own admission you are going along at about 25 percent of the rate Secretary Richardson recommended to this committee 2 years ago. Yet you say to me you seem to think that is adequate.

MONITORING SELECTED INDUSTRIES

Let me ask, I know there are a lot of Americans who have been affected by asbestos and other chemicals which cause cancer because of past exposure. As I understand there is only one small group of former employees in Tyler, Tex. under surveillance by NIOSH. That means in most surveys while you may check people who used to work at a place for purposes of scientific studies, a lot of times that is done on a sampling basis and not done for the entire work force, and in many cases the workers who may have been exposed are not even contacted. Isn't that really a pretty dismal record? I am not blaming you, I am suggesting the country ought to be doing a better job than that.

Dr. **Sencer**. I think we lack the legislative authority at the present time for the Federal Government to do this. As I understand the Occupational Safety and Health Act, next year we will be in a position where we can monitor people in selected industries.

I do know legislation has been introduced in the Senate that would speed up this process to set up registers of people in certain occupational categories so there would be a better mechanism of monitoring their continuing health.

ADDITIONAL FUNDS FOR NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

Mr. **Obey**. Let me ask this and I would like you to answer this Dr. Edwards. What additional funds are being made available to the National Institute for Environmental Health Sciences for toxicological and other studies.

Dr. **Edwards**. The budget for NIEHS is remaining somewhat stationary.

CANCER INSTITUTE

Mr. **Obey**. Let me ask this: I am told that the National Cancer Institute has no organized program in the area of occupational cancer.

I don't know if there ought to be one, whether it is scientifically sensible to do that or not. But it seems to me that people in the workplace face a much greater risk of cancer because of what they work with than people in other areas of the economy, and I wonder whether we are going to get this going.

Dr. EDWARDS. The National Cancer Institute has a very extensive toxicology program which involves many, many substances both industrial and nonindustrial.

Mr. OBEY. What is the increase for that?

Dr. SIMMONS. That went from 56 million in fiscal year 1974—chemical carcinogenesis—to 70 in 1975.

Mr. OBEY. How much from last year's budget to this year's?

Dr. SIMMONS. It was 66 million in 1974 and it is up to 70.8.

Mr. OBEY. $4 million?

Dr. SIMMONS. Right.

UTILIZATION OF ADDITIONAL FUNDS BY NIOSH

Mr. OBEY. That is not much is it?

Dr. Edwards, do you really feel that NIOSH could not productively use more money and more positions to prepare those criteria packages?

Dr. EDWARDS. I am certain that NIOSH could use more money and more positions as a number of other of our programs could use more positions and more money. Nevertheless, in the final analysis I suspect we could all agree there is so much available for the health programs and in the judgment of the administration this is the amount of resources that could be allocated for NIOSH activities.

Mr. OBEY. How many years is it going to take, given our present budget pattern, before you have criteria packages for all of the chemicals which workers are exposed to in the workplace?

Dr. EDWARDS. That is a difficult question. I suspect if the Congress and the executive branch continue to have priority programs like the cancer program that takes over a half a billion dollars each year that obviously we are going to have other programs which are inadequately funded, at least in your judgment and mine.

Mr. OBEY. Congress didn't recommend you hold the level of all other National Institutes of Health at last year's level. You recommended that.

Dr. EDWARDS. Nevertheless you know and I know that the Office of Management and Budget has a total dollar figure that we all have to live with, and we have to accept their judgment on that overall figure.

Mr. OBEY. I understand. We are not talking about that. Obviously there are going to be cuts in other areas of the Federal budget. It seems to me, given the total job to be done here, that this kind of standpat budget in the NIOSH area is unconscionable.

Dr. EDWARDS. Again I think you have a point. Obviously they could use more money if we had the money available, but this is the way we had to allocate the total available budget resources. That is about all one can say about it.

Mr. OBEY. That is all, Mr. Chairman. Thank you.

Mr. FLOOD. Mr. Shriver.

Mr. SHRIVER. Thank you, Mr. Chairman.

MALDISTRIBUTION OF HEALTH SERVICES

Dr. Edwards, in his health message to Congress this year the President noted the need to improve health service distribution in the country, and he mentioned the administration intends to encourage State, local, and private authorities to modify some existing laws relating to health regulations licensing, planning, production, and manpower allocation. Would you comment on the specific problems in these areas?

Dr. Edwards. That is a large question to answer in the detail that you want.

Mr. Shriver. Why don't you then put it in the record?

Dr. Edwards. May I do that in some detail in the record because we got into the manpower issue yesterday, and there are many complicated issues that the States have to address themselves to. We are trying in the administration, and so is Congressman Rogers and others, to upgrade the quality of health planning. We are trying in our proposed bill to upgrade the regulatory efforts of the States. So I would like to put that in some detail in the record.

[The information follows:]

STATE HEALTH INITIATIVES

Several States are beginning to implement new concepts of health resources policy designed to improve their health delivery systems. Among these are the States of South Carolina and Wisconsin.

SOUTH CAROLINA

To centralize health funds and management, the State of South Carolina created a unique health policy and planning council. In turn, the council established a central source of State and Federal health and human development funds to be meted out with the State by the council in a more rational and manageable way. The flow of moneys through the council is expected to begin shortly as soon as regulations are waived that require channeling funds directly to State agencies.

The council's mission is to establish health policy, set priorities, establish an investment schedule to achieve specific objectives, create a medical management information system, and develop a process to assess progress. It is already a step beyond State certification-of-need legislation, which many States have enacted to help allocate health resources where they are most needed, such as determining the location of hospitals.

The council recently launched a survey to identify health resources and their achievements in an effort to eliminate duplications and overlaps and determine where program gaps exist. With this data the council plans to assess accurately and promptly the impact of its policies on health resource allocations. A prime objective is to make health care accessible to all, and one of the first actions of the council will be to help set up a statewide system of family practice residencies.

Essentially the council will centralize funds and act as a subcontractor to State agencies. When the monies are diverted to the council, all requirements for public funds will have its prior approval before they are submitted to Washington, Atlanta, or the South Carolina General Assembly. The funds will be spent in accordance with the intent of the legislation.

Membership of the council includes a chairman, 10 health care consumers, and 9 health care providers, including physician heads of State health-related agencies and 2 physician delegates to the South Carolina General Assembly.

To date, there are few criticisms about the health council concept. The large infusion of State funds has helped to allay objections from State agencies.

WISCONSIN

The past 18 months have seen major changes in the organization structure, program content, and policy systems of Wisconsin State government in relation to the broad health field. Legislation enacted during 1973 created a health policy council that reports directly to the Governor's office. This advisory group, a majority of which represents the interests of consumers of health services in Wisconsin, is responsible not only for advising on State comprehensive health planning activities but for serving as the mandate advisory council for a variety of federally supported programs such as facilities construction, drug abuse prevention, alcoholism control, community mental health center development, and programs for the developmentally disabled. In addition, the council serves in a policy advisory role related to, but independent from, its health planning activities.

During 1973, the health policy council:

Developed a set of priorities for implementing recommendations of health task forces;

Developed and approved a State certificate-of-need bill which is consistent with Federal programs but specific to Wisconsin's needs;

Approved State plans in drug abuse, alcoholism, facilities, and developmentally disabled fields.

To strengthen the Council's role, the Wisconsin legislature created a Division of Health Policy and Planning to function as a supporting group to the Council as well as a policy advisory unit to the executive office and legislature. The Division acts independently of existing State agencies with health-related responsibilities, and has statutory authority to coordinate the planning activities of the several State agencies involved in State affairs.

During 1973, the division:

Participated in Federal evaluation of areawide health planning agencies in the State;

Developed a capital expenditure review program to enable the State to qualify as a decisionmaker under provisions of Public Law 92–603, for which the State will receive an additional $225,000 in Federal assistance;

Completely revised the State's comprehensive health planning procedures to increase input from nongovernmental and governmental agencies in the development and implementation of the State plan.

The health policy council and the division of health policy and planning utilized the "Report on the Governor's Health Task Force" which recommended the creation of the council and division as a basic plan for operations. Considering the wide scope of the task forces investigations and breadth of its recommendations, considerable effort toward implementation occurred during 1973. Among the achievements in 1973 toward supporting the task force goals were the following:

Passage of legislation providing a statutory basis for health planning in the State;

Passage of legislation permitting hospitals to employ physicians on a salaried basis;

Passage of legislation permitting enrollment of title 19 beneficiaries in prepaid health plans;

Passage of legislation mandating uniform boards under section 51.42;

Passage of legislation restructuring inpatient mental health services in State and county institutions;

Administrative action toward developing affiliation between the State's medical schools and hospitals in the State as a means of improving medical education and training throughout the State;

Expansion of enrollment at both medical schools in the State as a means to increase physician supply.

NATIONAL CENTER FOR HEALTH EDUCATION

Mr. SHRIVER. The President also mentioned the intention to establish an Office of Health Education within the Department of HEW. I am wondering what existing functions would be included in this and what would be added?

Dr. EDWARDS. As you know, Congressman, some time ago the White House put together a commission to study the whole subject of consumer health education. This group made a report to the President some months ago recommending a number of things, including the establishment of a focal point in the Federal Government for consumer health education. Although we spent enormous amounts of money in the field of consumer health education, there really has been no focal point for coordinating what we were doing. Our efforts have been widely disbursed and sometimes less than effective.

They also recommended in this report that a joint private-public national consumer health education center be established.

Mr. **Shriver.** Is that the National Center for Health Education?

Dr. **Edwards.** Yes. We have taken the first step in implementing these recommendations, namely, in designating a focal point within the Department to be certain that our efforts in the consumer health education field are effective.

This is just getting underway. Dr. Sencer is in charge of this effort, and we have placed in the 1975 budget $3 million. That is in addition to the many millions of dollars we are spending in consumer health education already in other programs.

Mr. **Shriver.** Would you look for private financing, too?

Dr. **Edwards.** This National Center which we are speaking of would have to be primarily funded from private sources.

Mr. **Shriver.** From what sources?

Dr. **Edwards.** I think there would be a number of sources we could get funds from. I think the insurance industry would certainly be one. The Blue Cross and Blue Shield would be another. Many of the health related industries, the pharmaceutical industry, the food industry, any number of industries of this type. I would expect to be financially supportive of this effort. It would be to their advantage from an economic point of view.

HEW—MOSCOW HEALTH LINE

Mr. **Shriver.** Is the new health line between the Department and Moscow located in your office?

Dr. **Edwards.** Not in my office. At the Parklawn Building.

Mr. **Shriver.** How is it being used?

Dr. **Edwards.** It is being used in a number of different ways. It is being used between our scientists to transmit information in a far more expeditious way than was formerly used. We have communicated frequently with the Minister of Health's office from my office certain agenda items; for example, for the World Health Organization. I think there are any number of ways.

Dr. **Sencer.** As an example, Mr. Shriver, we have been noticing in tourists returning from the Soviet Union, particularly Leningrad, there has been a very high incidence of an intestinal parasite that causes dysentery, much more so than any other parts of the world. We were going to publish this in our weekly morbidity reports to alert the public to it, and we used the health line to Moscow to let them know so we didn't appear to be striking at the health of the Soviet Union unfairly.

COMMUNITY MENTAL HEALTH CENTERS

Mr. **Shriver.** I understand you are again proposing to terminate Federal assistance for startup costs for additional Community Mental Health Centers. It is nothing new. You say this assistance will be replaced by insurance payments under national health insurance.

Dr. Edwards. Of course in the 1974 budget the Congress passed, we are planning some new starts for new Community Mental Health Centers, but we are not planning any new starts in our budget for 1975. We plan in 1975 to continue to fund those already in existence.

Mr. Shriver. I understand that. But in the future?

Dr. Edwards. It is our intention, depending upon what you in the Congress decide, to eliminate new starts in the mental health area.

DEVELOPMENT OF A NATIONAL HEALTH POLICY

Mr. Shriver. Would you put into the record more about your working partnership you mentioned in your statement among the executive and legislative branches of the Federal Government and State and local governments, the leadership of the private health sector, the academic community, industry, and consumers of health services. It is a pretty large group to get working together. Put in how you intend to go about mobilizing all of these forces to come up with a national health policy and specify plans for carrying it out.

[The information follows:]

The "working partnership" of which I spoke derives from a conviction that the American people share the basic goal of healthful and productive living.

The reorganization of the health components of HEW, which we accomplished last year, was undertaken, in large measure, to insure that Federal health policies, as they develop, would be properly focused and that the health concerns of the Federal Government could be expressed with the strength of a single voice. Individuals, outside groups—whether public or private—can now relate to a more unified health establishment rather than having to confront several more or less autonomous health bureaucracies.

I have met personally with literally hundreds of groups and individuals during the past year to discuss formally or informally our current health initiatives and concepts. When one adds to this the contacts between members of my office and outside groups or individuals, the numbers leap into the thousands. These contacts have included Members of Congress and staff of congressional committees. We have been extremely fortunate, I think, in having the responsible contributions of so many legislators, health professionals and institutions, and consumers in sharing their ideas, data, and experiences with us.

In order to provide for ongoing stable exchanges between my office and representatives of outside organizations, institutions and groups, I have reestablished with a new and broader charge the Office of Health Liaison. This Office works closely with the Secretary's Special Assistant for External Affairs (who handles similar functions for the entire department) and with the health agencies and our regional offices to disseminate information on what we are doing to all interested persons, often to solicit their comments on or ask their reactions to our proposals and those of others.

The "decentralization" of the majority of our programs to the Regional Offices has, we think, strengthened our ties to and enhanced our working relationships with State and local governments. As this process continues, we see every prospect of this aspect of our partnership becoming increasingly more effective in the administration of the Nation's health programs along with providing us with a better sense of our opportunities to be of service as well as the constraints imposed by local variation.

Recent efforts to coordinate Federal health programs have included intradepartmental activities to more closely aline the financing programs of Social Rehabilitation Service and Social Security Administration and the planning and services programs of the Public Health Service. My office is also currently engaged in very active and promising discussions with the Veterans' Administration and the Department of Defense on how we might better share our responsibilities for addressing the country's total health needs in manpower, quality review, and other areas. I think greater cooperation among the major Federal health agencies is already being achieved.

The partnership between the legislative and executive branches is symbolized by, but not limited to, the hearings process itself in which we are afforded the opportunity to promote and defend our proposals and programs. It is a forum in which they may be meaningfully compared with alternative programs and proposals, enhancing our national policymaking process.

Almost all of our programs are required, either by legislation or by administrative policy, to insure consumer input into our decisionmaking processes. This includes health services, health planning, professional standards review organizations, and many other activities. We also attempt to balance advisory committee and council membership to provide broad representation of diverse consumer interests. I think both the Congress and this department are firmly committed to permanent, meaningful participation by consumers in the development of our Nation's health policies.

Through "working partnerships" such as these we hope to contribute substantially to the development of sound and responsible health policies.

PROFESSIONAL STANDARD REVIEW ORGANIZATION

Mr. NATCHER. In your statement to the committee you stated, Doctor, that the Professional Standards Review Organization effort is one of the important steps for increasing the effectiveness of our health care system.

Dr. Edwards, as you know some of our physicians don't agree with that. What can you say to the committee that we could pass along to these doctors who are very unhappy with this particular program? Is it successful, will it be successful?

Dr. EDWARDS. Congressman, I think very frankly it is far too early to say whether it is or isn't successful. I think only time will tell.

I think, though, I would certainly say that if it is going to be successful, and that is a big if—I think its success is going to depend entirely upon whether or not the private practicing doctors in this country really take hold of it and run with the program. I think we are trying to given them every opportunnity we can. It is a program that isn't going to work if it is run by a Federal bureaucarcy. It has to be run with peer review at the local level by practicing physicians.

I think there has been a lot of misunderstanding about the program. Naturally the medical profession at this point in time feels that the noose is tightening a bit, and perhaps it is. But nevertheless I think that the law was written by the Congress in a way that gives the medical profession every opportunity in the world to control this program. But like most Federal programs, if they don't the Federal Government will probably have to step in and do it. The basic structure is there for it to be a success and for it to be a success via the private practicing community.

Mr. NATCHER. You believe then we should continue under this program and not make an effort, as some want, at this time to have this law repealed?

Dr. EDWARDS. I certainly don't think the law should be repealed. I think the Congress should watch it very, very closely because I believe, and I think Dr. Simmons would agree, there probably are some amendments to the law that should be made.

I think Dr. Simmons might want to speak to this. We are already beginning to look at ways of recommending changes to you and the Congress.

The basic idea of quality control is a good idea because the quality of health care delivered in this country varies from place to place. I think that there are many, many opportunities, as the Chairman pointed out yesterday, to upgrade the average. That is really what we are talking about.

Mr. NATCHER. How do you feel about it Dr. Simmons?

Dr. SIMMONS. You are talking to a pretty biased observer, but I guess I could honestly say, if this program works as it could, it could have the greatest favorable impact on quality care in this country of anything the Congress has ever enacted. I honestly believe that is its potential.

I think you should understand that there are also many physicians in this country who support and understand the need for this kind of a program. You do hear from organized medicine. Anything new is fearful. If I didn't understand the program, I would have my own fears about it.

I believe the way the law is written, and with some possible amendments that might be appropriate as we go along, it is basically a good law, that it gives to the profession the responsibility and the opportunity to regulate itself in the public interest. There are many first-rate physicians in this country and some very important scientific organizations that have endorsed the concept and are working very hard with it. I believe it can work.

Dr. NATCHER. Dr. Edwards, I want to say to you it is always a pleasure to have you appear before our committee. I think we are indeed fortunate to have you serve at this time as the Assistant Secretary of the Health, and as one member of this subcommittee I hope you stay on now. I say that to you frankly.

Dr. EDWARDS. I appreciate your kind words. Thank you.

Mr. FLOOD. Mr. Robinson.

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

Mr. ROBINSON. Initially, Doctor, I would like to get back for a moment to NIOSH and some of the comments that were made by Mr. there is a very important interrelationship between NIOSH and OSHA which has been acknowledged.

When he was here, his priority was on getting additional people for OSHA that are in the regulatory and enforcement field rather than in the field of education, which appears to me to be highly necessary because of the misunderstandings we acknowledge exist between OSHA and particularly the small employer.

In your planning for NIOSH I wonder to what extent the problem is recognized and to what degree you will be increasing your educational effort as far as NIOSH is concerned in addition to the standards that you are developing?

Dr. EDWARDS. May I ask Dr. Sencer to speak to that.

Dr. SENCER. Mr. Robinson, OSHA and NIOSH have joint planning meetings. We plan our programs jointly and our programs are reviewed jointly by OMB so that we try to make sure that the Departments of Labor and HEW are going forward in a manner that is compatible and we are not competing with each other.

In terms of the educational side, NIOSH has the authority to visit small industry or large industry at their request or at Labor's request to determine whether there are correctable hazards in the workplace, and we are called upon frequently to do this.

We are in the process this month of completing a survey of some 2,000 different industries, working out of our regional offices, to determine what are the health hazards we had not known of before, and this information will be turned back to industry as an educational rather than as a regulatory mechanism.

When we do walk through a plant and do find something that is a serious health hazard, it is our responsibility, of course, to notify OSHA so they can take corrective action.

Just recently in Wisconsin we went through a print shop at their request. It was a joint request of management and labor. We have found a disturbing fact. There were three cases of leukemia diagnosed in a fairly short period of time in the workers in this printing establishment. We are now taking a bigger look at the printing industry to see whether this is happenstance or we can determine there is a cause and effect relationship. If there is a cause and effect relationship, what can we remove from the environment that will prevent it from occurring?

Mr. OBEY. If the gentlemen will yield, true, you went into that print shop in Wisconsin all right. But isn't it also true the study was delayed a year or a year and a half because of the nonavailability of a physician until the union itself produced a physician who went over those records on a volunteer basis? Doesn't that study you are bragging about show how inadequate your budget is?

Dr. SENCER. I don't know about that situation. The problem with physicians is a very acute situation at the present time. As you know, we are——

Mr. OBEY. But you are using all your money to contract out.

Dr. SENCER. But we are no longer able to recruit physicians through the draft mechanism. So NIOSH has had a very difficult time in terms of getting physicians. This is why they have had to contract out or use volunteers to do the work.

Mr. OBEY. I think it comes with ill grace for you to brag to the gentleman from Virginia about that specific study.

Dr. SENCER. I wasn't trying to brag, sir. I was trying to put it in the record that we are trying to do things.

INTERCOOPERATION BETWEEN NIOSH AND OSHA

Mr. ROBINSON. With further regard to intercooperation between NIOSH and OSHA, do you participate in the seminars that are held with regard to the educational efforts in this area that OSHA, I think, mainly sponsors in the educational safety program?

Dr. SENCER. I am sorry I can't answer that question. I will supply it for the record.

[The information follows:]

No, however, we have cooperated with OSHA on several other educational efforts in the past and will continue to do so in the future. Our Division of Technical Services in cooperation with the NIOSH regional offices has begun pilot consultative services to small businesses program which does provide on-site safety and health consultation to small businesses to assist them in complying with the act. These consultations are self-initiated within certain standard industrial classification (S.I.C.) categories and are carried out in each type of industry long enough to develop fact sheets which have broad application to all small industry within each S.I.C. code.

Our Division of Technical Services provides a wide range of technical assistance activities to industry. Briefly, we respond annually to thousands of written and telephone requests on technical matters, and provide direct onsite industrial hygiene and medical investigations upon request from employers or employees.

We are further extending our impact on the working population by utilizing the knowledge gained by such investigations in developing criteria for standards and educational materials such as good work practices manuals oriented around specific occupations, pamphlets on specific hazards, and informational packets on health and safety problems commonly encountered in various types of small businesses.

OCCUPATIONAL SAFETY AND HEALTH SEMINARS

Mr. Robinson. OSHA, of course, does conduct seminars, and the complaint has been made that the seminars are too far apart and insufficient in number. If there is any way that NIOSH could assist so that these seminars are conducted with greater frequency and for a greater number of industries, I think that the problems that exist, and they do exist—would be substantially alleviated. Of course NIOSH being the Agency that is prepared to give onsite consultation is particularly important because OSHA can't give this kind of consultation to the end that the program is understood and the employer becomes willing to cooperate in the program rather than resisting it, which is all too evident with the program as it is presently administered. I wonder if you would react to the NIOSH attitude with respect to this matter?

Dr. Edwards. Dr. Key, who will be here later, will be able to comment on that.

Mr. Robinson. I will be happy to defer it.

Dr. Sencer. I would appreciate it. I am not familiar with that part of the program, Mr. Robinson.

ORGANIZATION PLACEMENT OF NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH

But, before I leave the subject of NIOSH what is the rationale for putting NIOSH with the Center for Disease Control?

Dr. Edwards. I think there is a good rationale, Congressman. I think first of all the Center for Disease Control is our organization that has the strongest relationship to the States and works closest to the State health organizations and other State groups that have activities relating to the health establishment.

In addition to that, I think there is no question that CDC is our prime epidemiological resource within the Federal Government, certainly within the Federal health structure.

There are other reasons too, but I think these two in and of themselves are sufficient reason for having NIOSH in the CDC organization.

Mr. Robinson. Does this indicate a philosophy on your part that it is extremely useful and presents a more balanced program if the functions of NIOSH and OSHA are tied as closely as possible to the State structures that exist in the same area?

Dr. Edwards. I think we have to take advantage of the State structures, yes.

PROFESSIONAL STANDARD REVIEW ORGANIZATIONS

Mr. ROBINSON. Regarding PSROs, you have already heard mention of the fact that there is substantial resistance to this program, and I don't have to tell you some of this resistance exists in my home State of Virginia. It exists in spite of the fact there was a strong support for the peer review system within the ranks of our doctors in Virginia, but because Virginia was divided into five regional areas rather than setting up one State level structure which they were prepared to support and have so stated in testimony before the Secretary. Mr. Casey of Texas made the same complaint.

It has come to my attention that in the process of review there were States which were reduced at least in the number of PSROs that were to be placed within that State as compared to the original number that was suggested.

I would ask you why it is possible to reduce some States and not others in terms of the original evaluation that was made?

Dr. EDWARDS. Again let me make several general comments and then Dr. Simmons can speak specifically as to how they came to the decision that they came to.

This has been, as you have indicated, a very, very difficult issue, the designation of these PSRO areas. Unfortunately at least in my own personal judgment, the congressional intent, particularly that of the Senate Finance Committee, was such that we had to set an arbitrary cutoff point in terms of the number of doctors above which we would have to have more than one PSRO or below which we could have a single State PSRO. We set this figure. Obviously there were a lot of States that didn't go along with it, Virginia being one of them. We gave Virginia a great deal of thought before the final decision was made.

We did cut the number of PSRO regions in some States. There were two States where we designated single State PSROs, the State of Georgia and the State of Washington. We had originally planned to have more, but I think their justification for a single PSRO was good.

Dr. Simmons, do you want to speak on this?

Dr. SIMMONS. First of all, I am sure you understand there is no way to divide up America and make everybody happy. That is one thing I have learned in 6 months. There is no way we could have satisfied all the competing interests all over the country from the planners to the Governors, the consumers, the physicians and to the hospital associations, most of whom couldn't agree among each other. So we have had to set up some criteria that we thought the legislation required of us and could be defended in the courts if necessary. I think we were able to set those up and adhere to them.

But with respect to Virginia let me make sure one thing is clear. Virginia does not want a statewide PSRO. None of the States who say they want a statewide PSRO in fact do want that. When you talk to them what they want is the ability of State level organizations to have a meaningful role in this program. They don't want to control the review, and they don't want to set the standards. I am sure no local group of physicians would let them do it. That is clear.

What Virginia wants we are able to offer them. Just as we are able to offer Texas, Illinois and all of the other States that are of that size.

Virginia wants the ability to influence the PSRO program and provide leadership. Under the statewide PSRO support center which we developed specifically to give statewide organizations a meaningful role they will be able to do it with direct funds from the Secretary.

They will be responsible for educating the professionals in Virginia about the program, stimulating peer review, helping them set up review organizations in their local areas, helping them with administrative and technical support, helping actually coordinate and evaluate the program in Virginia.

We think that is exactly what they want because all of them when you go to talk to them say "Look, the review, the standard setting, the disciplining of the profession, that is the local physician's job." By definition the law says that a PSRO is a local group of physicians who set standards and review care. That is who we have to contract with under the legislation. Our counsel has been through that with us many, many times. That is what we have done throughout the country and that is what we have done in Virginia.

I do hope that Virginia and other States will realize that basically the program has much to commend if we don't get hung up on the details.

Mr. ROBINSON. I understood it was your job to do this and not the job of the doctors in the State, and so far you have not satisfactorily accomplished this objective within the health delivery services area of Virginia. And if you have any proof of the fact that such philosophy exists, I wish you would furnish it to me with respect to Virginia, because everything I have from the hospitals and from the doctors and from everybody else concerned with the health delivery service in Virginia indicates otherwise and that they do want a single PSRO in the State.

Dr. SIMMONS. That is what I mean. It is a play on words. They do not.

Mr. ROBINSON. You say it is a play on words, but it is your job to convince them it is a play on words.

Dr. SIMMONS. We are sure trying to do it.

Mr. ROBINSON. It hasn't been done.

Dr. EDWARDS. There has been considerable misunderstanding on this. I think the point Dr. Simmons makes is a good one. I don't think anybody disagrees on the fact that the peer review has got to be at the local level. We think we have come pretty close to giving them what they want.

Again, there are words involved here in this State PSRO support center.

As a matter of fact I know if you gice me the managerial tools that we are giving the State PSRO support centers, I can certainly control the State PSRO system to the extent that I could provide them with managerial services, with information systems services, and so forth.

We are hung up on words and that is partly our fault. There is no question about it. We have to communicate better to the practicing profession. On the other hand, we all have to admit there is a resistance here that I am not sure all of the communication in the world will totally solve.

Mr. ROBINSON. To conclude this colloquy, I would point out that you emphasize in your own presentation this is a voluntary program.

Dr. EDWARDS. Absolutely.

Mr. ROBINSON. I would also point out to you that the Secretary when he was before us, and these are his words, suggested the possibility of "substantial interference" with the practice of private medicine as it has been known in the past. "Substantial interference" being his words. I think we need to guard against this in terms of willingness of the doctors to participate on a voluntary basis.

Dr. SIMMONS. To speak to that point, clearly that would be a very, very sad thing if that ever happened. But the way the legislation is written, if there is interference in the individual practice of medicine, it will be by the peers of that physician, because they are the ones who set the standards, not the Government. They are the ones who evaluate the care, and they are the ones who make the final judgment that Federal funds have been well expended. The Government is not in that process.

You know that is a tough issue when a physician says: "Now I am going to have to let other fellow physicians around me share in that judgment as to whether we are doing a good job." That is what the law says. That is not Government interference, that is interference by his fellow physicians. I think that is a basically sound process.

NUMBER OF PSROS TO BE FUNDED

Mr. ROBINSON. I suggest to you, Dr. Simmons, the Secretary was not referring to that area at all but rather to the voluntary participation in the program by the doctors themselves, and I think he will verify this.

You mentioned the funding at the level of $58 million and that you plan to have signed agreements with 120 PSROs by the end of fiscal year 1975. I would like to inquire as to how you ascertained this figure of 120 and the distribution that you suggest in your justification as to the way it will be distributed among the 120.

Dr. SIMMONS. That is clearly an estimate, Mr. Robinson. As I said yesterday, we already have over 300 letters that have recently come into the program expressing interest throughout the country in coming forward to be the PSRO. We would say that if one-half to a third of those are serious, it is reasonable to assume we will have 120 planning contracts going. Chairman Flood's district in fact is going to be the first State PSRO support center. We will be signing that contract in the next week or so.

There is a great deal of interest in this, and it is hard to know how many we will have by the end of the year. I think that is a reasonable estimate. That is, by the way, not a signed agreement, that is a planning proposal.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. ROBINSON. If I may turn for a moment to HMOs, you have $37 million in planning and initial development with regard to the health maintenance organizations for fiscal year 1975, and I wonder about the distribution of that $37 million with regard to the States in which it would be spent. I would ask unanimous consent, Mr. Chairman, if a table exists you can provide as to how that money is going to be utilized with regard to the various States, I would like to have it part of the record.

Mr. Flood. Without objection, that will be done.

Mr. Buzzell. Actually, there is no table and there will not be a table. The HMO program will not be distributed on a State-by-State basis. It is not a formula grant program.

Mr. Robinson. This was going to be my next question. It appears that in most of your programs you are trying to stay as much with a State-oriented program as possible. I was going to ask the extent, if any, to which the HMO program was going to be State-oriented?

Mr. Buzzell. Essentially not at all with the exception of two things. We will be turning to the comprehensive health planning groups in the State for their advice.

Mr. Robinson. The regional planning groups?

Mr. Buzzell. They are not regional planning groups.

Mr. Robinson. They are in Virginia.

Mr. Buzzell. Yes. But so-called comprehensive health planning agencies, the State agencies as well as the so-called B agencies. So that is a role they have in reference to the HMO program.

There is another area where the HMO program will become directly involved in providing HMO-type services to the medicaid population. We will have contracts with the State medicaid agencies in order to provide that coverage in States like Virginia and other States as we are doing in California now. We have that program in the States, Mr. Robinson.

EMERGENCY MEDICAL SYSTEMS

Mr. Robinson. If I may add to my request something which slipped my attention.

On page 8, Dr. Edwards, you talk about emergency medical services. This may have been covered for the record already. I have heard substantial criticism of this, as it is proposed, because of the possible interference as would be indicated in my State of Virginia, for example, with the voluntary organizations that exist in the area of emergency medical services which we think are well trained and which do a good job and which are locally financed without the necessity of any significant Federal taxpayer assistance. They feel that this is a possible area where Federal control will be exerted over these volunteer rescue squads and other such agencies to such an extent that they will no longer have the autonomy they have had in the past.

Will you react to that?

Dr. Edwards. I think one of the things we are striving to do is to be certain that this is a demonstration program, and that it does not become a federal system.

Of course, being the matching program that it is, the initiative has to come from the State groups in order to get Federal funding. I think the likelihood of these fears materializing is remote.

Mr. Robinson. You do not visualize another burgeoning bureaucracy?

Dr. Edwards. We have seen that in government often enough to know it is always a possibility. Certainly, the initial intent is not to create another Federal bureaucracy but, rather, to have the initiative come from the State. I think with the matching formula the way it is, this is likely to happen. Certainly, the States have to put up or shut up on this one.

Mr. BUZZELL. Yes. Let me add one comment, if I may, Dr. Edwards.

First of all, the voluntary groups have nothing to fear. There is nothing in the legislation that requires them to participate in the program. To the contrary, the legislation places priority on our providing assistance to the States and to the local governments. They are in the first cluster of priority, and that is of concern to the local groups.

The training program which Dr. Endicott and I will be administering will provide training money to those voluntary groups. They will be able now to come to the State or to the local government and place their people in a training program which we will subsidize between the States and the Federal Government.

The fear they have is warranted, but again I think we have come to a better understanding as to how the program is to work.

The legislation also speaks of a statewide system. They have a feeling that they are getting into that statewide system or arrangement. They do not have to. They are not required to.

Mr. ROBINSON. They are required to if they participate.

Mr. BUZZELL. Yes. The requirement goes like this. The State and local governments are required to take a systems approach to the introduction of the EMS system before they can get Federal funding. There is clearly a desire on the part of the fathers of this legislation to pull together the components which currently are in fact pretty well diffuse. We have a good transportation system in one particular area of your State, but no linkage with the communications network.

I really do not think they need to be unduly concerned. I think they end up far better off.

Mr. ROBINSON. That is all, Mr. Chairman.

REGIONAL OFFICE REORGANIZATION

Mr. CONTE. As I understand it, a major feature of your reorganization has to do with regional offices. It's certainly something that keeps coming up when we deal with specific health programs and in our mail. Will you outline that reorganization?

Dr. EDWARDS. The reorganization of the PHS regional offices has occurred as a part of the overall PHS reorganization.

One component of this reorganization was to establish the position of the Regional Health Administrator—RHA—as the principal health official in the region, reporting directly to me. The RHA is responsible for regionalized health programs and activities which, under the overall PHS reorganization, are supported by several of the PHS health agencies.

The second major component of the PHS regional office reorganization was to create a basically consistent but flexible structure for all regions. This structure provides for three staff offices for Planning and Evaluation, Management Support, and State Coordination. Five divisions are established: Financing and Health Economics, Health Services, Quality and Standards, Prevention, and Health Resource Development. Simliar programs have been grouped by division to maximize organizational efficiency, improve program implementation and facilitate coordinated use of available expertise.

In addition, each regional office will be designating persons to function as the principal focal point for each major categorical program. These regional program consultants will provide liaison with their counterparts in headquarters, provide specialized consultation as needed, and assure that all programmatic requirements are carried out in the PHS regional offices.

In summary, this reorganization is a major factor in my efforts to strengthen the role of my representative in the regional office, the RHA, by improving his capability to direct and control all PHS regional components and resources and provide a structure for carrying out decentralized responsibilities more effectively and efficiently while assuring implementation of our categorical program responsibilities.

DECENTRALIZED PROGRAMS

Mr. Conte. Do you have any kind of independent evaluation going of the way decentralized or "regionalized" programs are working?

Dr. Edwards. We are currently developing an evaluation study to assess the implementation of PHS activities developed specifically to facilitate and monitor decentralization. This study will focus primarily on the Regional Health Administrator's work program, which is a new system based upon principles of management by objectives which involves: establishing and selecting organizational objectives and plans based upon national program guidance, specifying the available financial and manpower resources which will be utilized to accomplish those objectives, and providing a process of monitoring progress and providing feedback. In addition, separate evaluation studies of specific health programs and projects are being conducted.

Mr. Conte. Do you think that there will have to be basic changes in medical education for practice under new delivery systems such as HMOs?

Dr. Edwards. Many of the services that constitute health maintenance can be provided more suitably by nonphysician personnel, including physician's assistants, nurses, medical technologists, and health educators. Such people can be trained to work in an HMO system in less time and at less expense than is required for the training of a physician. The major change needed in medical education would involve training physicians to work with and make the most use of such people. Obviously, it will be necessary for medical schools to collaborate with allied health and nursing schools in order to provide such training.

PARTNERSHIP BETWEEN GOVERNMENT AND HEALTH COMMUNITY

Mr. Conte. You mention the need for partnership among Government branches and private sectors of the health community. Over the last 2 years the academic community has expressed its concern about its diminishing role. Are you making any special efforts to rebuild or reestablish that relationship?

Dr. Edwards. We are grateful for the continuing invaluable assistance we have received from members of the academic profession, and remain proud of our longstanding relationships with them particularly with regard to the National Institutes of Health.

For example, Dr. Stone, the Director of NIH, has recently given speeches before the American Association of Medical Colleges and the Association of Academic Health Cetners. NIH scientists constituted an entire panel at the last meeting of the American Association for the Advancement of Science, and heavy participation from this Department is expected at the upcoming conference of the Federation of American Societies for Experimental Biology.

Communication is not a one-way street, however. Members of the academic community are very important for the advice they provide on advisory committees and in initial review of grants. Opinions and data provided by the academic community also had a profound effect on the administration's decision to reinstate an amended version of the research training program.

In conclusion, although ideologic conflicts are bound to occur as both parties work for improvements in the health care system, we are confident that existing mechanisms provide for postive resolution of these varying viewpoints, and look forward to a continued partnership between the Assistant Secretary for Health's Office, the other health agencies and components of DHEW and the academic community.

REGIONAL MEDICAL PROGRAMS

Mr. CONTE. You're not requesting continuation of regional medical programs. Outside of the cancer and heart programs, what specific efforts do you have to build research results into the health care system?

Dr. EDWARDS. There are no special program efforts comparable to those specifically authorized in the areas of cancer and heart disease, directed at introducing biomedical research results into the health care system, putting them into widespread practice.

Two important corollary points must be made in this regard though. First, the diffusion on new knowledge and technologies in health, as in all fields, is a complex social process that we imperfectly understand at best; and thus, it is not one we can readily program or "manipulate" with any high degree of confidence of success.

The second point is that there are a number of federally aided efforts which are accelerating or indirectly promoting the widespread introduction of health services as well as biomedical research results, and indeed the oft painful lessons of experience and trial-and-error, into the health care system. To cite but two illustrations:

The broadening of medicare to include payment for end-stage kidney disease treatment for nearly all Americans, regardless of age or financial circumstances, doubtless will accelerate the spread and use of new surgical techniques, and related instrumentation; and under the EMS legislation enacted late last year, improved EMS system approaches that have proven successful in a few cities and counties will be seeded with the help of Federal funds in many, many more communities throughout the Nation.

UNDERUTILIZATION OF PARAPROFESSIONALS

Mr. CONTE. Is the problem with paraprofessionals in health care, underutilization or lack of highly trained personnel?

Dr. Edwards. In answer to your question, sir, as to why health-care services are not readily available to certain segments of the population and how this problem relates to the use of paraprofessionals, I submit the following material for the record.

[The information follows:]

Manpower Utilization

Part of the problem with unavailability of health-care services in certain areas is associated with a maldistribution of highly trained health personnel and inefficient use of time by highly skilled manpower. Solutions to both of these problems are being sought by the introduction of new types of paraprofessional health workers, particularly physician assistants and nurse practitioners, who are trained to perform routine, time-consuming tasks usually performed by physicians. A number of States are utilizing these types of health personnel in geographical areas that do not attract or are not able to support the numbers of highly trained health professionals that might be needed. In each case, these physician assistants and nurse practitioners work under the supervision of a physician.

Although intensive evaluation studies of the effectiveness of the new categories of health personnel are presently being conducted, preliminary indications are that they have been successful—in providing health services where previously few or no services existed—and in increasing the efficiency of physicians.

A number of States have recently amended their nurse-practice acts to expand the functions that can legally be performed by nurses (e.g., Idaho, Arizona, New Hampshire, Washington), and 35 States have passed legislation to legalize the employment of physician assistants. Approximately 500 physician assistants have been approved by State agencies for employment in the last two years.

In spite of these legislative actions, there are still some potential legal and administrative problems associated with utilization of these new kinds of health workers. One problem is to adequately define their scope of practice and to determine the requisite amount of supervision. Another is to develop criteria to evaluate training programs. Still another problem is to determine how these personnel fit into the health-care picture along other, more-established categories of health workers. Also, some physicians are reluctant to employ physician assistants and nurse practitioners because of fear that it will increase their chances of malpractice suits. It should be pointed out that there is no evidence so far to justify this fear.

Regardless of the problems normally inherent in the evolution of new types of manpower, physician assistants and nurse practitioners are gaining increasing acceptance and increasing numbers of States are taking steps to permit their utilization.

Mr. Conte. Are there any plans being considered for decentralizing research?

Dr. Edwards. There have been occasional discussions of the possible decentralization of a small number of functions relating to the fiscal management of grants. This would permit the regional offices of the Department to interact directly with the fiscal officers of the institutions to whom the grants have been awarded. On the other hand, the process of review and awarding of grants has been and should continue to be a centralized process in which the competition among scientists is on a national basis. Only by continuance of this policy will it be possible to select the very best applicants from among the large pool. There are no present plans for decentralizing any aspect of the grants management or awards process.

Mr. Flood. Thank you very much, gentlemen.

Thursday, March 21, 1974.

HEALTH SERVICES ADMINISTRATION

Health Services

WITNESSES

HAROLD O. BUZZELL, ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION

DR. DAVID SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL

DR. ROBERT VAN HOEK, ASSOCIATE ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION

DR. FAYE G. ABDELLAH, DIRECTOR, OFFICE OF NURSING HOME AFFAIRS, PHS

DR. PAUL B. BATALDEN, ACTING DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES

DR. MICHAEL J. GORAN, ACTING DIRECTOR, BUREAU OF QUALITY ASSURANCE

DR. ROBERT E. STREICHER, DIRECTOR, FEDERAL HEALTH PROGRAMS SERVICE

DR. CARL SHULTZ, ACTING ASSOCIATE ASSISTANT BUREAU DIRECTOR FOR FAMILY PLANNING SERVICES

W. HARELL LITTLE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, HEALTH SERVICES ADMINISTRATION

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WILFORD J. FORBUSH, DIRECTOR, DIVISION OF BUDGET FORMULATION/OS

OBJECT CLASSIFICATION (IN THOUSANDS OF DOLLARS)

	1973 actual	1974 estimate	1975 estimate
Personnel compensation:			
Permanent positions	84, 060	97, 644	97, 754
Positions other than permanent	3, 975	5, 157	3, 246
Other personnel compensation	4, 515	4, 568	4, 887
Special personal services payments	375	375	375
Total personnel compensation	92, 925	107, 744	106, 262
Personnel benefits: Civilian	13, 685	15, 826	15, 817
Benefits for former personnel		218	
Travel and transportation of persons	3, 634	4, 716	4, 477
Transportation of things	1, 309	1, 656	1, 654
Rent, communications, and utilities	3, 622	3, 778	8, 618
Printing and reproduction	562	578	714
Other services	18, 442	34, 855	28, 637
Project contracts	17, 035	18, 738	28, 496
Supplies and materials	11, 047	13, 035	12, 236
Equipment	2, 498	3, 743	3, 258
Lands and structures	74		
Grants, subsidies, and contributions	558, 451	735, 646	722, 665
Insurance claims and indemnities	17		
Subtotal	723, 301	940, 533	932, 834
Quarters and subsistence charges	−209	−210	−210
Total obligations	723, 092	940, 323	932, 624

PERSONNEL SUMMARY

	1973 actual	1974 estimate	1975 estimate
Total number of permanent positions	7, 609	7, 309	7, 400
Full-time equivalent of other positions	432	427	416
Average paid employment	7, 609	7, 581	7, 661
Average GS grade	6. 6	6. 6	6. 6
Average GS salary	$6, 588	$6, 788	$7, 050
Average salary of ungraded positions	$9, 381	$9, 722	$9, 801

PROGRAM AND FINANCING (IN THOUSANDS OF DOLLARS)

	1973 actual	1974 estimate	1975 estimate
Program by activities:			
Direct program:			
1. Community health services:			
(a) Community health centers	110, 770	217, 100	200, 400
(b) Comprehensive health grants to States	89, 092	90, 000	90, 000
(c) Maternal and child health:			
(1) Grants to States	113, 239	132, 678	243, 951
(2) Project grants	93, 100	104, 595	
(3) Research and training	19, 473	21, 917	21, 917
(d) Family planning	104, 437	150, 024	100, 615
(e) Migrant health	22, 223	23, 750	24, 000
(f) HMO grants and contracts			45, 000
(g) HMO loans and loan guarantees			15, 000
(h) National Health Service Corps	11, 974	9, 787	9, 255
2. Patient care and special health services	95, 912	104, 511	109, 184
3. Buildings and facilities		2, 000	12, 030
4. Program management	23, 538	33, 588	35, 783
5. National health service scholarship program		3, 000	
6. Regional office central staff	5, 407	5, 909	
Total direct program	689, 165	898, 859	907, 135
Reimbursable program:			
1. Community health services:			
(a) Maternal and child health	102	200	100
(b) Family planning	3, 070	4, 500	5, 500
2. Quality assurance			5, 774
3. Patient care and special health services	14, 527	20, 956	21, 043
4. Program management	4, 971	5, 808	75
Total	22, 670	31, 464	32, 492
Total program costs, funded [1]	711, 835	930, 323	939, 627
Change in selected resources (undelivered orders; stores)	11, 257	10, 000	−7, 003
Total obligations	723, 092	940, 323	932, 624
Financing:			
Receipts and reimbursement from:			
Federal funds	−17, 448	−25, 163	−26, 150
Trust funds	−4, 719	−5, 733	−5, 774
Non-Federal sources	−503	−568	−568
Unobligated balance, start of year			−5, 463
Unobligated balance transferred from other accounts		−3, 213	
Unobligated balance, end of year		5, 463	1, 736
Unobligated balance lapsing	50, 719		
Unobligated balance restored		−48, 731	
Budget authority	751, 141	862, 378	896, 405
Budget authority:			
Appropriation	751, 295	860, 280	896, 405
Transferred to other accounts	−154	−372	
Appropriation (adjusted)	751, 141	859, 908	896, 405
Proposed transfer for civilian pay raises		2, 442	
Proposed transfer for military pay raises		28	
Relation of obligations to outlays:			
Obligations incurred, net	700, 422	908, 859	900, 132
Obligated balance, start of year	318, 788	261, 764	338, 315
Obligated balance transferred, net	−73, 183	3, 638	
Obligated balance, end of year	−261, 764	−338, 315	−338, 667
Adjustments in expired accounts	−10, 803		
Outlays, excluding pay raise supplemental	673, 460	833, 601	899, 655
Outlays from civilian pay raise supplemental		2, 317	125
Outlays from military pay raise supplemental		28	

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[1] Includes capital outlay as follows: 1973, $2,498,000; 1974, $3,743,000; 1975, $3,258,000.

Notes: Includes $4,284,000 in 1975 for activities previously financed from other accounts. Comparable amounts for 1973 and 1974 are $4,100,000. Includes $116,500,000 in 1974 and 1975 for activities previously financed from other accounts. Comparable amount for 1973 is $116,500,000. Excludes $18,890,000 in 1975 for activities transferred to other accounts. Comparable amounts for 1973 ($15,414,000), 1974 ($18,801,000), are included above. Excludes $634,000 in 1974 and 1975 for activities transferred to other accounts. Comparable amounts for 1973 ($603,000) are included above.

BIOGRAPHICAL SKETCH

Mr. **Flood.** Now we have the Health Services Administration, the presentation to be made by Harold O. Buzzell, the Administrator of the Health Services Administration.

We will place your biographical sketch in the record.

[The biographical sketch follows:]

Curriculum Vitae—Harold O. Buzzell

Birthplace and date: Oakland, Maine, February 14, 1932.
Marital status: Married—four children.
Education: University of Maine, 1959, B.A.

EXPERIENCE

1973–Present: Administrator, Health Services Administration, U.S. Department of Health, Education, and Welfare.

1973: Administrator, Health Services and Mental Health Administration, U.S. Department of Health, Education, and Welfare.

1972–73: Deputy Manpower Administrator, Department of Labor.

1970–72: Vice president and managing officer, Studies and Analysis Division, Booz, Allen, and Hamilton.

1969–70: Managing officer, Financial Management Services Division, Booz, Allen, and Hamilton.

1966–69: Vice president, Federal Division, Booz, Allen, and Hamilton.

1963–66: Consultant/associate, Booz, Allen, and Hamilton.

1962–63: Assistant controller, Guilford Industries, Guilford, Maine.

1959–62: Division controller and cost accountant, Scott Paper Co., Chester, Pa.

1957–59: Laborer/clerk/bookkeeper, Ounegan Woolen Co., Old Town, Maine.

1955–57: Clerk, Lancaster's Grocery, Veazie, Maine.

OPENING STATEMENT

Mr. **Flood.** I see you have a prepared statement, which we will also place in the record.

[The statement follows:]

Statement by Harold O. Buzzell, Administrator

HEALTH SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the committee, I am pleased to have this opportunity to discuss with you the programs of the Health Services Administration and to present our budget request for fiscal year 1975.

As you know, Mr. Chairman, the Health Services Administration was formed as a result of the major reorganization of health programs within the Department of Health, Education, and Welfare which took place last year. It includes those programs of the Public Health Service which deal with the accessibility, delivery, and quality of health care available to the American people. We in the Health Services Administration consider it an exciting and challenging constellation of programs whose combined mission is at the heart of the Federal role in health.

Four major bureaus and services make up the Health Services Administration—the Bureau of Community Health Services, the Bureau of Quality Assurance, Federal Health Programs Service, and the Indian Health Service. Because the appropriation request for the latter is heard by another subcommittee, I shall confine my testimony to the first three mentioned.

BUREAU OF COMMUNITY HEALTH SERVICES

This new Bureau brings together six major categorical health services delivery and support programs—community health centers and family planning services, including all former OEO health service projects; maternal and child health; migrant health; National Health Service Corps; and health maintenance organizations. These programs were established to meet the health care needs of communities or specific segments of the population:

Community health centers provide ambulatory health care programs in urban and rural areas where health service access has been a particular problem.

Family planning services are aimed at persons desiring but unable to afford such services, primarily those with low income.

Maternal and child health services are directed toward mothers and children in economically depressed areas.

Migrant health projects are designed for that special population group—agricultural workers and family members who periodically travel from one place of work to another in pursuit of crop harvesting or cultivation employment.

National Health Service Corps provides teams of health personnel in areas of health manpower scarcity.

Health maintenance organizations provide comprehensive health services to enrolled populations on a prepaid basis.

Community health centers ·

Through this project grant program over 150 ambulatory health care projects are supported which provide primary health care and develop arrangements for specialty and inpatient care, particularly in areas where health care is scarce or nonexistent. The 1975 request of $200.4 million reflects a decrease of $5.1 million in this activity. Recent experience indicates that the decrease will not adversely affect the number of patients served or the quality of services provided because of anticipated increased effectiveness in the management and operation of the projects.

In 38 States, the District of Columbia, and Puerto Rico, through 118 neighborhood health centers, which include all of the projects initiated by the Office of Economic Opportunity and transferred to this Department over the past 4 fiscal years, about 1.2 million persons are receiving services. These centers constitute an important community health resource for persons who live in areas of high morbidity and mortality.

Effectiveness of neighborhood health center approaches is reflected in the results of a number of completed studies which show that reductions from 25 percent (general patient population—Chicago) to as much as 50 percent (children—Rochester) have been found in the number of hospitalizations among center users. Based upon such findings, one can project annual savings of nearly $50 million in hospitalization costs for the populations served by the 118 neighborhood health centers.

In another study, having to do with the effectiveness of comprehensive care programs in preventing rheumatic fever, it was shown in areas served by three such programs in Baltimore that there was a 60 percent reduction in the rate of rheumatic fever for children aged 5 to 14.

Currently there are 39 family health centers in 31 States and the District of Columbia, 25 of which are operational. The remaining 14 will complete their developmental work in 1974. In the 25 operational centers, services are provided on either a fee-for-service and/or prepaid basis. It is estimated that the 39 centers will serve 105,000 people in 1975.

Comprehensive Health Grants to States

This $90 million grant program assists States in establishing and maintaining adequate public health services. State health and mental health agencies continue to utilize these funds to assist in the support of a broad range of basic health programs, projects and activities at State and local levels. In 1975 we anticipate that States will maintain the 1974 service level.

Maternal and Child Health

A major legislative action affecting maternal and child health programs was the enactment of Public Law 93–53 on July 1, 1973 extending maternal and child health project grants for an additional fiscal year. Because conversion to formula grants would have resulted in increases in total State funding in some States and decreases in others, this amendment indicated the legislative intent of holding "harmless" the populations served in 1974. To help implement the "hold harmless" provision in 1975, $25 million will be distributed under section 516.

In addition $10.5 million in released 1973 project funds will be distributed for use in 1975. This use of project funds is dependent on extension of project grant spending authority beyond June 30, 1974.

An additional aspect of the title V legislation is the provision that services continue to be provided in 1975 and thereafter to the same population groups as previously served under the project grant program. All States are also required to include a program of projects in their State maternal and child health plan. This will result in the establishment of some 162 new projects in the areas of maternity and infant care, intensive care of newborns, children and youth comprehensive health care, dental health care of children and family planning services.

The maternal and child health programs have made significant contributions to recent reductions in the Nation's infant and maternal mortality rates. These reductions have been especially significant in areas served by the maternity and infant care projects. For example, the infant mortality rate in the Baltimore project area has been decreased from 26.8 to 21.9, in Albuquerque from 22.7 to 12.2, in Miami from 23.7 to 2.5 and in Denver from 40.0 to 9.0 since these programs have been in operation.

It is anticipated that with the $244 million requested, the same number of people will receive services in 1975 as in 1974.

The $15.9 million training grant program has as its main purpose the support of university-affiliated centers for the mentally retarded for the purpose of expanding the supply and competence of personnel working with mentally retarded children and their families. The 1975 request also continues the program initiated in 1972 to train nurse midwives, pediatric nurses and other physicians' assistants. Approximately 340 professional health personnel will receive specialized long-term training. In addition, short-term training will be provided to approximately 3,600 graduate and undergraduate trainees. The 1975 research grant request of $6 million will continue support of studies designed to improve the operation, functioning and effectiveness of maternal and child health and crippled children's services.

Family Planning

Family planning project grants provide comprehensive contraceptive, medical, educational, and social services including tests for cervical cancer, anemia, and venereal disease, to an estimated 1.6 million individuals who otherwise would not receive these services. This significant national effort has undoubtedly improved the lives of many people who otherwise would have suffered the medical, economic, and social consequences of unwanted conceptions. It is useful to consider that the Planned Parenthood Association estimates that for every dollar spent delivering family planning services, $2½ are averted on required medical and social services in the first year of life.

Because family planning services are now available in 85 percent of all counties, our program emphasis has changed from the establishment of new programs to the expansion of operating projects. In addition, we are encouraging grantees to improve their management of the smaller project grants.

Migrant Health

During 1974, 355,000 persons are expected to receive services involving about 630,000 patients visits. A uniform utilization and cost-data reporting system has been initiated in 1974 which is expected to provide projects with data which will provide the necessary financial management, evaluation and planning tools to improve their ability to deliver services. In cooperation with the Social Security Administration, Bureau of Health Insurance, a special demonstration project is underway to provide additional hospital care to a group of migrant farmworkers and their families. This project will also gather data on the utilization and cost of hospital services for use in further improvements in health services to this population.

Under the 1975 request of $24 million, activities will continue generally at current levels. Using the $250,000 increase requested, additional efforts will be directed to improving service delivery in low impact areas.

Health Maintenance Organizations

We are requesting $60 million in 1975 for the new health maintenance organization program. As I expressed to you a few weeks ago in my testimony supporting the HMO supplemental appropriation request for 1974, we are most eager to begin implementation of the new HMO legislation. This is certainly one of the most significant programs in the health field in terms of its potential impact on health care in the Nation. In 1975, our request includes an increase of $15 million for grants, all of which will be used to support the increased number of initial development projects, as the planning projects from the previous year become eligible for additional assistance. Although we are requesting $20 million less in 1975 for the direct loan and loan guarantee fund, this does not really represent a decrease in our program level, since these funds are used to complete the capitalization of the revolving fund. The program support category remains at $5 million reflecting decreased requirements for contracted technical assistance and a compensating increase for direct operations due to annualization of our initial 1974 staff support costs, and a requested increase of 25 new positions.

National Health Service Corps

This program represents a new and expanding approach in the Federal effort to improve health care of people residing in areas of this country with a critical health manpower shortage. In January 1972, the Corps had approved 16 communities and placed 20 health professionals in those communities. By the end of 1974 staff will have been recruited and matched to the needs of approximately 220 communities. During the first quarter of 1975 over 400 health professionals will be serving these communities.

The 1975 budget requests $9.3 million and authority to recruit an additional 146 health personnel for field assignments which would provide health services to another 55 communities.

BUREAU OF QUALITY ASSURANCE

The Health Services Administration is deeply involved in the area of medical care standards.

Our Bureau of Quality Assurance is providing increasing leadership in the development of health care standards for the medicare and medicaid programs. Special efforts have recently focused around the development of a single set of utilization review requirements and skilled nursing facility standards for the medicare and medicaid programs. Our surveyor training efforts are designed to maintain and update the skill and capacity of surveyors on duty as well as those newly employed.

Another major objective of our quality assurance program will be to develop the conditions of participation in the chronic renal disease program and implement this activity.

The results of these efforts will be reflected in improving the quality of care provided in direct service projects and in the translation of the quality assurance activities into a more effective consultation with the major Federal financing programs.

The 1975 request of $5.8 million and 224 positions will continue the 1974 level for non-PSRO quality and standards activities. The Bureau of Quality Assurance has operational responsibility in the implementation of the PSRO program. The budget for the PSRO program appears in another part of the HEW appropriations request—Office of the Assistant Secretary for Health appropriation.

FEDERAL HEALTH PROGRAMS SERVICE

The Federal Health Programs Service administers the patient care and special health services programs which include the operation of the PHS hospitals and clinics, the Federal employee health program, the medical program of the Coast Guard, and payments to the State of Hawaii for care of persons with Hansen's disease.

We are requesting $109.2 million in 1975 for this activity. This represents an increase of $4.5 million over 1974.

Patient Care—PHS Hospitals and Clinics

The primary beneficiaries of the PHS health care system are American seamen and uniformed members of the Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service. In addition, other Federal beneficiaries and foreign seamen may receive care in the PHS facilities. Individuals afflicted with Hansen's disease are eligible for care at the National Leprosarium, Carville, La., and at other PHS facilities.

Through the first 7 months in fiscal year 1974, our inpatient load in the PHS hospitals including the Carville Leprosarium has averaged 1,469. However, the monthly patient loads have continued to increase as the year has progressed, and we now project that our inpatient workload will average 1,520 for the year. As we further expand the utilization of our facilities in 1975, we expect our inpatient workload to average 1,780. In fiscal year 1973, our average daily patient load was 1,655. Outpatient visits to PHS facilities will total 1,470,000 in 1974, and we expect that figure to rise to 1,557,000 in 1975. As we increase the capabilities in the PHS hospitals, we anticipate that the number of our beneficiaries who receive care through contractual arrangements with non-PHS hospitals will decrease in 1975. In 1974, we estimate that this patient load will average 100 per day and we expect this to decrease to 90 patients per day in 1975.

With regard to the long-range continuing utilization of the hospitals, we have established a task force within the Public Health Service to define the position and roles of the PHS general hospitals and their relationships with other departmental programs. It is expected that the task force will recommend ways in which the hospitals can be better utilized to the benefit of this program, as well as to programs of those health agencies and communities which may utilize the capabilities of the PHS hospitals.

The 1975 budget requests $99.1 million, an increase of $4.3 million for patient care. Of this amount, $2.7 million is for mandatory increases. These amounts will permit us to continue the current levels in operating the eight PHS general hospitals, the Carville Leprosarium, and the 30 outpatient clinics. The amount requested will also permit us to meet the added patient care workloads projected for 1975. The remaining $1.6 million, a new item in the budget, is requested to provide health care to participants in the Public Health Service study of untreated syphilis and to members of their immediate families who have suffered physical injury of disease as a result of contracting syphilis from study participants. This program will be administered by the Center for Disease Control.

Coast Guard medical and Federal employee health programs

In 1974, care is being made available to approximately 138,000 Coast Guard personnel and their dependents. Outpatient medical and dental visits will be in excess of 600,000 for the year. A total of 14,000 inpatient days are anticipated in Coast Guard medical facilities. Contracts for care in non-PHS hospitals will account for an additional 29,000 inpatient days, and agreements with local physicians will account for 19,000 additional outpatient visits. The 1975 budget request of $8.3 million will continue this program at the 1974 level.

The Federal employee health program will continue to provide health care services to 180,000 Federal employees in 103 health care units operated by the Public Health Service. In addition, it will provide consultation to other Federal agencies planning on establishing health care units. The 1975 request of $5.6 million will continue the 1974 level.

PROGRAM MANAGEMENT

The program management activity includes a request for $35.8 million and 903 positions, a net increase of $2.7 million and 10 positions over the 1974 level. This budget activity supports the management activities of the Bureau of Community Health Services, the Federal Health Programs Service, and the Office of the Administrator.

For the Bureau of Community Health Services, $24.5 million and 637 positions are proposed to administer and improve 6 major health programs—Community Health Centers, Comprehensive Health Grants to States, Maternal and Child Health, Family Planning, Migrant Health, and the National Health Service Corps. An increase of 10 positions is requested for additional management support to the National Health Service Corps.

For the Federal Health Program Service, $2.8 million and 95 positions are requested for headquarters activities related to managing the PHS hospital system and other direct and indirect medical care programs.

This request includes $3.9 million and 171 positions to support the Office of the Administrator in our efforts to direct and coordinate the programs included in the Health Services Administration.

SUMMARY

In summary, Mr. Chairman, we are requesting funds totaling $896,405,000 and 7,365 positions. This request will enable us to maintain the level and quality of services provided by these programs in 1974 and increase our initiative in two high priority areas—Health Maintenance Organizations—25 additional positions—and the National Health Service Corps—156 additional positions.

Mr. Chairman, I will be pleased to respond to any questions with regard to our programs and budget requests.

COMMUNITY HEALTH CARE CENTERS

Mr. FLOOD. Let us begin with the community health care centers.

Of the funds requested by the community health care centers, how much is for the family health centers and how much for the neighborhood health centers?

Mr. BUZZELL. $13 million is for the family health centers, and $187 million for the neighborhood health centers. Of the total of $200 million, most goes for the neighborhood health centers.

REBASED 1973 FUNDS

Mr. FLOOD. How are you spending the $6 million of the 1973 money that we released in 1974?

Mr. BUZZELL. In section 314(e), we are spending it specifically for the family health centers.

Mr. FLOOD. Will any of that released 1973 money be used to fund any of the 2-year grant awards, that is, cutting down or reducing the support level required in fiscal year 1975 funds?

Mr. BUZZELL. No, it will not, Mr. Chairman.

IMPROVED MANAGEMENT

Mr. FLOOD. In the budget justification there is quite a story. You state you expect to save $5,100,000 due to improved management. We are for that. Will you explain more fully what you mean by management improvement, and give the committee some examples of what you mean by that?

Mr. BUZZELL. Yes, sir.

Let me point out that there has been a $5 million reduction. In addition to that, as you know, health-care costs are going up. In order to insure that we provide at least the same level of services and cover the same number of people, we have had to work closely with the projects to improve their ability to get money from other sources—particularly, third-party reimbursement sources such as the medicare and medicaid programs.

We have been very successful in doing this. We probably could have done it more aggressively in years past. For example, these neighborhood health centers that we talked about——

Mr. FLOOD. Not "probably"; "absolutely."

Mr. BUZZELL. I agree.

EXAMPLES OF IMPROVED MANAGEMENT

Mr. FLOOD. You should make quite a record on this. Suppose you just give us some examples for the record. Suppose you give us two now.

Mr. BUZZELL. I would like to give you the very important one of the neighborhood health centers. Working with these centers, if we collect the maximum potential amount, we will have been able to recapture approximately $9 million this past year which we will put right back into the projects. That $5 million that I talked about is offset almost 200 percent by the third-party collections.

Again, that is collections not from the patients, but from the medicare, medicaid, and other insurance programs.

Beyond that, many of our projects, as one would expect, were less than totally effective in terms of serving people. They were not seeing enough patients. We have and will continue to work closely with them to improve productivity.

It is that kind of improvement that, through our technical assistance, we have been able to achieve with the projects.

For example, again, if the patient is entitled to medicaid, then it is important that the grantee have the ability to find that out so they can collect from the medicaid program.

It is working quite well. It is important that it work well because we have had, as you know, this $5 million reduction in our budget request.

[The information follows:]

EXAMPLES OF IMPROVED MANAGEMENT

A number of actions are underway to improve the financial and general management capabilities of project grantees, with particular emphasis on the neighborhood health centers supported under section 314(e) of the PHS Act.

Illustrative of these are:

1. Application of the project inventory process in 84 neighborhood health centers, as described in the testimony of Dr. Batalden, followed by provision of technical assistance in fiscal and overall management expertise to correct deficiencies identified.

2. Installation of information systems and cost-accounting systems for meeting national reporting requirements and for internal management. This activity includes provision of technical assistance to projects on development and operation of data systems.

3. Conducting of seminars for regional office and project staff to concentrate on management, monitoring, and evaluation uses of data from national reporting systems.

4. Conduct a survey of administrative agencies for the major third-party payors (titles XVIII, XIX, and IV-A) to clearly define and analyze reimbursement policy and procedures. The results will assist individual ambulatory health-care projects to understand utilization and cost data third-party payors require in negotiating reimbursement rates and to determine their potential for reimbursement with each of the plans.

5. Support of external medical audits and the development of internal medical audit capability by the project.

The objective and anticipated results of project inventory are demonstrated by these two examples:

Projects	Potential reimbursement in estimated total operation		Actual reimbursement in estimated total operation		Total operation increase	
	Amount	Percent	Amount	Percent	Amount	Percent
Rural project—Pennsylvania	$216,000	22	$199,000	18	$17,000	4
Urban project—New York	784,000	26	543,000	17	241,000	9

As a result of technical assistance provided through a one-time supplemental grant award in 1974 to a large urban project in Massachusetts, an accounts receivable and patient identification system will be developed and installed. It is expected this will result in increased collections of $300,000 in 1975 as a result of more effective billing and better identification of health benefit entitlement of patients.

THIRD PARTY PAYMENTS

Mr. **Flood.** Again, in the justifications you say that the collections from all these third parties are at a level of 13 percent.

Mr. **Buzzell.** Yes, sir, 13 percent for the neighborhood health centers.

Mr. **Flood.** And maybe 20 percent would be feasible. Are we to assume that a 20-percent collection is the tops, the maximum, that a neighborhood health center can collect from third parties?

Mr. **Buzzell.** Yes, that is correct. We can collect only about 20 percent of the total operating costs of centers because many of the people we serve are not entitled to medicaid, medicare or other third party benefits. Those programs are fairly narrow. Unlike the comprehensive health insurance, they do not cover all the enrollees. 20 percent is about the top.

Mr. **Flood.** Suppose you do not achieve that saving of $5.1 million. What happens then?

Mr. **Buzzell.** We are doing it. That is what I wanted to put in the record.

I can probably state it a better way. This next fiscal year, we will serve more people than we did this year, in spite of the $5 million reduction.

You will ask me next spring about this.

Mr. **Flood.** As sure as God made little apples.

Mr. **Buzzell.** We are going to do it, that is all.

COORDINATION OF ACTIVITIES

Mr. **Flood.** On the coordination of activities, putting these things together, how do these neighborhood health centers coordinate their activities with those of the family planning program and the centers for disease control? In the case of the CDC's, I am referring to the matter of immunization. Then we have the patient education activities.

Mr. **Buzzell.** May I defer to Dr. Batalden, simply because I do not know the answer.

Dr. **Batalden.** Mr. Chairman, a number of our existing neighborhood health centers have extensive family planning services under the family planning grant program sponsored under title X. As well, a number of our neighborhood health centers are serving as active immunization clinics in connection with the Center for Disease Control.

We will provide an elaboration of this for the record.

Mr. **Flood.** We want that, yes.

[The information follows:]

The following neighborhood health centers have family planning services sponsored under title X:

Denver Department of Health and Hospitals.
Trustees of health and hospitals of the city of Boston.
Homewood-Brushton Neighborhood Health Centers, Inc., Pittsburgh, Pa.
Metro-East Health Services Council, Inc., East St. Louis, Ill.
Hennepin County Pilot City Health Center, Minneapolis, Minn.

With respect to CDC relationships, the Center for Disease Control has responsibility for four project grant programs. Project grants are provided, typically to official health agencies at the State and local level, to carry out immunization programs, venereal disease control programs, rat control programs, and lead-based paint poisoning prevention programs. Although national data on the extent of cooperation between these grant assisted programs and neighborhood health centers is not maintained, these control programs are directed toward public health problems which are particularly acute in populations such as those served by neighborhood health centers. Project guidelines, for each of these programs, therefore, stress cooperation between the grantee and such community health organizations and agencies as neighborhood health centers, free clinics, and others.

Cooperation in carrying out immunization programs include the provision of vaccine and education materials to health center clinics, and assistance in carrying out immunization campaigns among the health center clientele. On occasion, project grant supported personnel have been assigned to neighborhood health centers on a full-time basis to carry out immunization programs.

The neighborhood health center also provides a valuable resource for the diagnosis and treatment of persons who are identified with elevated blood lead levels or with venereal disease. These centers also participate in carrying out screening programs for both of these conditions. For example, during fiscal year 1973, over 340,000 women were tested for gonorrhea in community health centers, including neighborhood health centers, and 11,000 of these women were identified with and treated for gonorrhea. Close cooperation is also maintained in carrying out venereal disease education and contact tracing programs.

Target areas for urban rat programs frequently overlap the neighborhoods served by neighborhood health centers, and cooperative programs of neighborhood education and problem identification are carried out. In some cities rat control project personnel train and utilize neighborhood health center outreach workers to carry out rat control programs in the center's area of responsibility, and in others the center relies on project personnel to carry out community involvement activities. "Block clubs," and other neighborhood health center outreach activities, are particularly useful in achieving the type of community involvement which is critical to the success of the urban rat control program.

Mr. FLOOD. How do you tie them all together—family planning, neighborhood centers?

Dr. BATALDEN. They are tied together through the activities of the regional offices and at the local level. The individual neighborhood health center serves as the community health center—a one-stop place——

Mr. FLOOD. CDC?

Dr. BATALDEN. Yes. They have CDC-sponsored immunization programs. This is done in conjunction with the State and local health departments through the programs' CDC monitors.

PER CAPITA COSTS IN NEIGHBORHOOD HEALTH CENTER

Mr. FLOOD. Of course, we are concerned about costs here. What is the cost per person for delivery of care in the neighborhood health center program, and how does it compare with the national average?

Dr. BATALDEN. The cost per person served in the neighborhood health center can be derived by simply dividing the total universe of the population served into the total budget, but that does not give you the detailed kind of cost breakout.

Mr. FLOOD. First of all, what is the cost per person, and how does it compare with the national average?

Dr. BATALDEN. I cannot give you that right now.

Mr. FLOOD. Find it.

Dr. BATALDEN. I will find it for you.

[The information follows:]

Based on a summary of 314(e) grant applications, 1973 funding from all sources for the 67 neighborhood health center was $138,760,401. During this same period, the estimated number of patients served in the centers was 675,620. Thus, the overall average estimated cost per person served was $205.

On a national level we do not have comparable information. However, data reported in the 1973 Statistical Abstract of the United States indicate that the national per capita cost for services which are most comparable to those delivered in neighborhood health centers is $187. This represents per capita medical expenditures for the total U.S. population. It is not directly comparable to the average expenditure per person receiving services shown ($205) for neighborhood health centers. A strictly comparable average could be estimated only if one identified the total number of citizens actually receiving services and divided the number into the total expenditures.

Mr. FLOOD. Is the cost per person going up in 1975, or is it decreasing?

Mr. BUZZELL. As an objective, as a goal, it will decrease.

Mr. FLOOD. That's great.

Mr. BUZZELL. Your question was: Is it going to or not? My prognosis is that it will decline, because that is a major initiative of ours. Once again, we want to expand services.

FAMILY HEALTH CENTERS

Mr. FLOOD. Now on the family health centers, your justification is quite a document. You state that you have finalized their benefit packages and have started enrollment activity.

That sounds like a health maintenance organization. Are these things in effect HMOs, or what?

Mr. BUZZELL. A number of the family health centers are converting or will convert to become HMOs. During the next fiscal year, we estimate that perhaps three will convert.

Mr. FLOOD. It seems from what you say in your justifications that many aspects, certainly some aspects of this program overlap the HMO program. What about that?

Mr. BUZZELL. I think some aspects of this program fit in well with the HMO concept—simply the notion of these people's receiving their services on a prepaid or capitation basis. In family health centers, the program intent was to test the feasibility of providing prepaid services to low-income populations in both rural and urban underserved areas.

There is quite a bit of interest on the part of the family health centers, neighborhood health centers, and the OEO-initiated networks that we have, to convert over or at least to be in part an HMO. We may use HMO legislation and funds to assist these projects.

HMO FUNDS

Mr. FLOOD. Will HMO funds, especially the part marked for what you call "nonmetropolitan areas," be used to support the rural family health centers?

Mr. BUZZELL. Yes; in some instances.

Mr. FLOOD. If that HMO money is available to support the family health centers, why is it necessary to provide separate funds for these activities in the family health centers? Which came first, the chicken or the egg?

Mr. BUZZELL. Let me use an example—Mr. Obey's Marshfield or our Marshfield Clinic. That clinic is in fact, at least in part, an HMO now. It does not fit the legislative definition of an HMO, but for all practical purposes it is in part an HMO. It is also a family he center, and funds are used to pay for a portion of the service delivery charges. This will no be the case in an HMO.

I ought to clarify one thing for the record, and that is that the HMO program money that we requested a month ago when we were here in connection with the supplemental request and in the 1975 budget request will not be utilized for the family health centers or neighborhood health centers. However, these centers may be converting to the HMC provider arrangement or the HMO concept.

Mr. Flood. But does the Federal Government pay the entire monthly premium cost in a deal like that?

Mr. Buzzell. Not the entire monthly premium cost, no, but we have paid in fact a portion of the capitation.

Mr. Flood. How many of the participants pay even a part of the monthly premium?

ENROLLEE CATEGORIES

Dr. Batalden. In the family health center program, there are three categories of enrollees.

Mr. Flood. That is a good way to begin.

Dr. Batalden. The first category is the person who can pay for services by virtue of some existing entitlement—medicaid, medicare, or private insurance.

The second category is those who can pay for the full premium themselves without the benefit of any type of insurance coverage.

The third category of enrollees are those who cannot themselves pay and for whom there is no existing insurance or entitlement.

It is for the category three enrolees that the family health center grant funds go to provide payment for the costs of services.

HOSPITALIZATION

Mr. Flood. How do the family health centers arrange for hospitalization?

Dr. Batalden. Through a variety of ways that have been really fairly creative. The family health center in Georgetown, for example, has an arrangement with a neighboring hospital that they were able to work out because they picked up a lot of the drop-in care the hospital ordinarily would have had to provide.

In the case of the Marshfield family health center, we extended to them a waiver that would allow them to pick up the cost of hospital care because we were interested in examining just how this waiver might influence their ability to market the package to the population they were trying to serve.

Mr. Buzzell. Generally it is a very difficult thing for them to do. No. 1, they do not have the funds to pay for hospitalization.

Mr. Flood. That is the understatement of the morning.

Mr. Buzzell. That is correct. Generally, it is very difficult for them to do.

The best example I have, I think, is the migrant health program. We do not have a mechanism in terms of providing hospitalized care for migrants. When a migrant goes to a migrant health center and requires hospitalization, then the project director has the very challenging job of finding an institution that can in fact take this patient.

Generally speaking, the State or the local community has carried that burden in a community hospital. They may be entitled to medicaid or medicare, or they may have some other form of health insurance. If that is the case, in fact it is our job in these projects to help them get the necessary hospitalization and arrange for the fiscal agent to cover them. But it is a problem.

PROGRAM COORDINATION

Mr. **Flood.** On maternal and child health, tell us how the activities of the maternal and child health program targeted to low-income families are coordinated with the activity of the neighborhood health centers and family health centers, which of course are also targeted to the low-income families.

Mr. **Buzzell.** The answer really is that we do not. We operate separate programs here. The maternal and child health program for a couple of key reasons is not closely coordinated with the neighborhood health centers.

First of all, it has become a State program, so it is being managed through the States.

Second, the kind of services and the target population with which they are dealing in the maternal and child health area are somewhat different from the neighborhood health center.

Mr. **Flood.** The immunization programs are supported under the maternal and child health program. Do they overlap or do they complement the immunization activities of the Center for Disease Control that we were talking about before?

Dr. **Batalden.** Most of the immuniztaion activities are coordinated through the regional offices and at the local level in conjunction with the local health department. They are not initiated autonomously for the population groups. They are done in concert with the local health department.

Mr. **Buzzell.** Again, the answer is, there is essentially no coordination with the Center for Disease Control. It is an independent program through the local health department, essentially.

Dr. **Batalden.** I think the coordination comes through the role that the Center for Disease Control plays with the State and local health departments. The Center for Disease Control has an extensive program that supports the development of these immunization programs through the State and local health departments. It is through these local health departments, then, that the effective coordination is achieved at the community level.

AUTISTIC CHILDREN

Mr. **Flood.** You also spoke in your statement about research training. Your justifications place a great deal of emphasis on training personnel to work with the mentally retarded children. Does this training include the autistic children, too?

Mr. **Buzzell.** Yes, it does.

Mr. **Flood.** Can you elaborate on some of the projects that you are currently supporting in the area?

Mr. Buzzell. Yes. Again, I will ask Paul to expand on this. We are supporting 20 university-affiliated centers for the mentally retarded. As you indicated, Mr. Chairman, the basic purpose is to provide services to the mentally retarded and multiply handicapped.

In addition to that, we will be continuing to provide nurse practitioner and physician assistant training programs through this activity.

Mr. Flood. How many pediatric nurses and physician assistants do you produce in this program on an annual basis?

Mr. Buzzell. In this fiscal year, we estimate 150 health personnel will receive training in areas like nurse midwifery, pediatric nursing, physician assistance.

Mr. Flood. That is great, but are you meeting the demand for this type of personnel?

Mr. Buzzell. The answer is, "No," but this kind of training is going on under a number of other programs as well.

FAMILY PLANNING

Mr. Flood. On the family planning program, in the budget justification, again, you say, "Continuing efforts are being made to integrate family planning projects within existing health systems."

Can you explain to the committee how you are going about this integration?

Mr. Buzzell. Either Dr. Batalden or Carl Shultz could answer that.

This would be a good opportunity to introduce Dr. Shultz to you, Mr. Chairman.

Carl, do you want to speak to that point, and then Paul will elaborate on it.

Dr. Shultz. Mr. Flood, as you are aware, essentially most family planning services that are delivered through organized planning are delivered through freestanding family planning clinics and facilities. However, we feel in order to expand the program satisfactorily, it is necessary to increase the services through other health service care delivery mechanisms, such as hospitals and neighborhood health centers or family health centers or any other health provider in the community.

This, of course, includes private physicians. We work with private physicians as well to encourage them to provide family planning services.

Basically, our objective is to expand the program most economically, and one of the ways is through the mechanism of using existing health care facilities.

Mr. Flood. Does integration mean the end of the freestanding family planning projects that we have?

Dr. Shultz. No, sir.

Mr. Buzzell. As you know, Mr. Chairman, if we have a large number of very small categorically defined clinics—that is, they only provide a few services while incurring all the attendant overhead and administrative costs—we end up not providing as much direct service as we would like to. We are doing some consolidation of small projects.

THIRD-PARTY PAYMENTS

Mr. FLOOD. What success, if any, have the family planning projects experienced in collecting from third parties? For instance, medicaid.

Dr. SHULTZ. They have had considerable success. It is estimated that in this fiscal year we shall obtain approximately 20 percent of the cost of organized programs from third-party payers.

Mr. BUZZELL. Let me make one point in that regard. I am afraid the chairman's question is: Why didn't you cut this one when you cut the neighborhood health centers $5 million?

Our information on third-party collectables in the family planning area is not as solid or as dependable as it is in the neighborhood health centers. We would like to achieve the 20 percent, and we think there is the potential there, but we have not demonstrated conclusively yet that we can do it.

In the neighborhood health centers, we have. So, we have some homework to do in that regard.

Dr. SHULTZ. This is really a report based on our regional program directors working with the States. I perhaps have more confidence in it than Mr. Buzzell does. I feel very confident we are achieving in this fiscal year at that level, and in the coming fiscal year we predict we will be able to achieve an even higher level, because the motivation is very strong.

We have the Social Security Act, titles XIX and IV-A, and a special provision of 90-percent Federal matching which act as a special incentive to the States and other areas to get this third-party reimbursement. Congress has acted in such a manner as to provide this incentive and, therefore, I think we can expect to move ahead rather directly in the area of family planning and obtaining a very high level of reimbursement.

The eligibility is somewhat greater here.

Mr. BUZZELL. My point is that the regulations are not out yet in terms of the 90-10 match and the results are not in at all. I believe we will achieve that. The fact is that we have not done it yet. At least, we are not collecting data that we can validate which says we are in fact collecting 20 percent.

I think Carl is right, the potential is good, and we need to focus on that, but meanwhile we are going to have to move with some caution in terms of direct grant money in the family planning area.

FAMILY PLANNING TRAINING

Mr. FLOOD. You also have in the budget a request for training activities. Let me quote again from your justification:

> To promote the skills and knowledge necessary to insure that all family planning staff have the skills necessary to successfully provide voluntary family planning services.

Is that available to the staffs of the neighborhood health centers, family planning centers, and MCH centers? Are they all in on that?

Mr. BUZZELL. No. This is just the family planning services area.

I think it is terribly important that we provide a substantial amount of training in the family planning area because, as you know, we get into some very sensitive areas in terms of sterilization, abortion, and a number of other things. We get into some very sensitive areas in terms of the kinds of data that we will distribute, the kinds of pamphlets that we will provide to the enrollees.

As a consequence, I think it is important that our people thoroughly understand what they are supposed to be doing. It is a very sensitive area. I think training in that area particularly is important.

This training activity that you refer to, Mr. Chairman, is in the family planning services area.

UNIT COST OF DELIVERING FAMILY PLANNING SERVICES

Mr. **Flood**. In your justifications you talk about reducing unit costs. What is the current unit cost, and what do you expect the unit cost to be in fiscal year 1975?

Mr. **Buzzell**. I shall defer to Dr. Batalden and Dr. Shultz. I would expect the answer will be that we are not sure.

Go ahead.

Dr. **Shultz**. We are carrying out an effort at the moment to determine what will be a good estimate of what the levels will be. However, on the basis of information which we have, we are able to estimate that we have been able to accomplish certain per capita reductions through the consolidation effort because we have indications that larger projects provide services at a lower unit cost.

An earlier estimate was around $60 to $65 per capita per annum as being the family planning services cost. We now estimate it will be closer to $55 to $60 per individual per annum for a comprehensive set of services.

Mr. **Buzzell**. What we are saying, I think, if I understand Dr. Shultz, is that per patient served, our costs are running, we think, approximately $60 per patient.

Dr. **Shultz**. And we anticipate some reduction.

DATA SYSTEMS

Mr. **Flood**. This one is always a can of worms. All through this budget justification you have reference to the development of the data systems and third-party billing systems. Are we to interpret this as one coordinated effort? Are you making one major effort to serve all the programs under this appropriation, or is each program going its separate way on this thing?

Mr. **Buzzell**. In the Department we have a very high priority in terms of data systems, third-party reimbursements and improved financial management systems in these projects. That is all-inclusive in terms of the programs that are covered by Dr. Batalden's Bureau of Community Health Services.

Mr. **Flood**. Is this a coordinated effort to develop a billing system, or what are you doing?

Mr. **Buzzell**. It is a coordinated effort between our regional personnel and our central office personnel and the project grant personnel to assist the projects to put in the kind of billing system and the kind of management system they need in order to get the funds they are entitled to, the purpose being to expand the services in each of the projects.

It goes across all our programs in the Bureau of Community Health Services as well as the programs in the sister agencies.

MIGRANT HEALTH

Mr. FLOOD. You spoke about the migrant health program. In 1974, you had $23.7 million. In 1975, you have $24 million. You are going up $250,000.

In your budget justification you state that the migrant health projects will improve access to quality health services for migrant workers and their families.

How are you going to increase access under that budget?

Mr. BUZZELL. To be honest, it is going to a very difficult. The third-party reimbursement mechanism—medicare, medicaid—does not serve the migrants and our budget request for increasing grants, as we indicated, is very nominal.

As a consequence, the only way we are going to be able to expand our services in terms of serving migrants is through becoming more effective or more efficient in the migrant projects.

Mr. FLOOD. That is an increase of $250,000. Are you going to use that in the migrant worker field to improve care to those working in the low-impact area?

Mr. BUZZELL. Low-impact area?

Mr. FLOOD. That is less than 6,000 migrants.

Mr. BUZZELL. Exactly.

Mr. FLOOD. How are you going to accomplish that?

Dr. BATALDEN. The main way we are going to do that, with additional funds, is to work with existing hospital outpatient departments and with existing clinics in those areas to pay for services for migrant farm workers and their families.

We recognze it is not a large additional sum of money, but we also recognize that our main problem in terms of coverage for migrant health services is in the low-impact areas. We have migrant health services available in the high-impact areas of the country; that is, those areas that have more than 6,000 migrant farmworkers.

Mr. BUZZELL. The fact is, we are not going to do it with grant money. However, we do have some hope that the State medicaid agencies will entitle many of these migrants to medicaid coverage. The reasons they are not covered now are, generally speaking, administrative-type reasons. They are going from one section of the country to another.

Mr. FLOOD. Are you improving the health status of migrants relative to that of the general population?

Mr. BUZZELL. Yes, we are, but I would say in the migrant area we have the furthest to go. As a population group, the health status is the worst of any of our population groups.

FISCAL MANAGEMENT PROBLEMS

Mr. FLOOD. Again, in your justification material you state that a team of experts identified fiscal management problems in the 13 largest migrant projects that you have. Can you tell us what problems the experts have found and what you are going to do about these problems?

Dr. BATALDEN. Yes. There are a number of specific problems in successful third-party reimbursement. They range all the way from whether in fact the individual project is recognized as a provider of services by the State medicaid program; second, whether the services that the individual center provides are in fact reimbursable; third, whether the patient who is being served is eligible to receive services; fourth, whether the rates at which they are able to bill are equivalent to the costs they experience in providing services; and, fifth, whether the billing is actually made.

The problems we run into as we look at each one of these centers is that there are a host of little things that make the difference—whether in fact there has been sufficient follow-through with the State medicaid agency as to the provider status of the clinic; whether an efficient billing clerk has been employed and has repsonsibility for determining whether in fact the individual has entitlement to those funds; and whether in fact the bill is sent and whether records are kept.

In these areas, we have been most effective in both identifying the problem and working with the individual projects to address the problem.

Mr. Flood. I have several questions that my colleague Mr. McFall, the distinguished gentleman from California, has asked me to have you answer for the record. Please do so at this point.

[The information follows:]

MIGRANT HEALTH PROJECT

Question. Please provide a list of the 103 migrant health projects which are being supported, with the dollars allocated to each one in fiscal year 1974.

Answer. See table below. Ninety-eight projects are listed on the table. Consolidations and mergers have taken place since the figure of 103 projects was used in the budget narrative.

Question. Please provide for each of the 103 projects the number of physicians encounters in the most recent grant year and the cost per encounter.

Answer. Data on the number of physician encounters per project are presented in the table below. These data were collected for the calendar year 1972 and are the most recent data available. For those projects which were not operational during calendar year 1972, there are no data available on physician encounters. The reporting requirements of the projects did not lend themselves to analysis of the data to reflect cost per encounter. The migrant health program is currently implementing cost accounting and national reporting systems which will yield data on the cost per encounter.

Question. How many projects provide care in the evening; in other words, outside regular working hours? Do you encourage this?

Answer. The migrant health program has continued to stress the need to provide care in the evening in order to make services accessible to migrants. Sixty-three projects provide care in the evening. See table below.

Question. How many of the migrant health projects provied care at more than one site or provide care through mobile clinics to make care more accessible?

Answer. Forty-seven projects provide care at more than one site. Ten projects provide care through mobile clinics. See table below.

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FUNDING FY 1974 AND SERVICE
CHARACTERISTICS

Region	Grantee	Location	Estimated Obligations FY 1974	Multi-Site	Mobile Clinics	Evening Hours	Dental Services	Physician Encounters
I	New England Farm Workers Council	Springfield, Mass.	$145,050	X				N/A
	Shade Tobacco Growers Assn.	Windsor, Conn.	145,050			X		7,221
II	School of P.H., Univ. of Puerto Rico	San Juan, P.R.	215,000*					8,512
	University of Rochester	Rochester, NY	89,575					2,761
	Board of Chosen Freeholders	Bridgeton, NJ	53,646*					4,621
	Ulster Co. Dept. of Health	Kingston, NY	25,077					357
	Salem Co. D.H. Bd. of Chosen Freeholders	Woodstown, NJ	29,336*					1,007
	Dept. of Health, Commonwealth of Puerto Rico	San Juan, P.R.	296,500					7,084
	Suffolk Co. Dept. of Health	Riverhead, NY	160,937					1,568
	Rochester General Hospital	Rochester, NY	274,471*					6,518
	Project REACH, Inc.	Perkinsville, NY	94,263*					2,320
	St. Anthony Community Hospital	Warwick, NY	112,731*					6,436
	Visiting Nurse Assn. Middlesex County, Inc.	North Brunswick, NJ	35,000					N/A
	Oak Orchard, Inc.	Rochester, NY	275,530					N/A
	Gloucester County, NJ	Gloucester, NJ	137,336					N/A
III	Pennsylvania Dept. of Health	Harrisburg, Pa.	211,939*	X		X		N/A
	Virginia State Dept. of Health	Richmond, Va.	122,012*	X	X	X	X	2,700
	District #6 Health Dept.	Martinsburg, WVa.	63,528	X		X		3,028
	National Migrant Workers Council	Washington, D.C.	185,797	X		X		N/A
	Delaware State Health Dept.		30,624					N/A
IV	South Carolina State Bd. of Health	Columbia, S.C.	76,871	X		X	X	2,855
	Dept. of Health & Rehab. Services	Jacksonville, Fla.	1,555,145*	X		X	X	74,519
	Henderson County Migrant Council, Inc.	Hendersonville, NC	84,629			X	X	1,472
	N.C. Dept. of Human Resources	Raleigh, NC	61,67[illegible]	X	X	X	X	927
	Sampson County Health Dept.	Clinton, NC	27,7[illegible]			X	X	422
	South Carolina State Bd. of Health	Columbia, SC	36,190			X		982
	Wilson County Health Dept.	Wilson, NC	1/-0-			X	X	3,900
	Johnston County Health Dept.	Smithfield, NC	21,500			X	X	3,308
	Community Health of South Dade, Inc.	Miami, Fla.	843,000	X		X		13,906
	Avon-Park-Frostproof-Wauchula Community Development Corp.	Frostproof, Fla.	223,586				X	N/A
	West Orange Farm Workers Health Assn.	Apopka, Fla.	161,508*			X		N/A

*Awarded
1/Carry-over balance will support continuation.
N/A: not available

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[illegible]	Grantee	Location	Estimated Obligations FY 1974	Multi-Site	Mobile Clinics	Evening Hours	Dental Services	[illegible]
V	Ohio Dept. of Health	Columbus, Ohio	$2[illegible]0,017			X	X	19,[illegible]
	Northwest Michigan Health Service, Inc.	Traverse City, Mich.	1[illegible]3,075	X		X	X	[illegible]
	Amos, Inc.	Indianapolis, Ind.	159,500*	X		X	X	[illegible]
	Health Delivery, Inc.	Saginaw, Mich.	3[illegible]3,22[illegible]	X		X	X	[illegible]
	Illinois Migrant Council	Chicago, Illinois	180,[illegible]	X		X	X	1,[illegible]
	La Clinica de Los Campesinos	Wautoma, Wisconsin	170,000	X	X	X	X	[illegible]
	Minnesota Migrant Health Services	Moorehead, Minn.	172,090	X		X	X	2,031
	Darke-Mercer-Shelby Regional Services, Inc.	Greenville, Ohio	85,500	X		X	X	N/A
	B.C.V. Health Services, Inc.	St. Joseph, Mich.	455,000	X		X	X	N/A
	Clinicas Migrantes Regional	Tiffin, Ohio	90,000	X		X	X	N/A
	Hartville, Migrant Council, Inc.	Hartville, Ohio	50,000			X	X	N/A
	S.O.L. Regional Health Services, Inc.	Fremont, Ohio	385,255	X		X	X	N/A
VI	Zapata County Texas Commissioners Crt.	Zapata, Texas	60,469	X				5,[illegible]
	Cameron County Health Dept.	San Benito, Texas	134,777					4,[illegible]
	Jim Wells County Commissioner's Crt.	Alice, Texas	51,803*			X	X	[illegible]
	Gonzales County Medical Society	Gonzales, Texas	140,800			X	X	5,[illegible]
	Community Action Council of So. Texas	Rio Grande City, Tex.	100,212*		X	X	X	3,[illegible]
	Catholic Charities, Inc.	Harlingen, Tex.	723,284	X			X	21,[illegible]
	La Salle County Commissioner's Court	Cotulla, Texas	65,118				X	6,[illegible]
	Las Cruces Committee on Migrant Hlth.	Las Cruces, New Mex.	36,720			X	X	3,[illegible]
	Jim Hogg County Commissioner's Court	Hebbronville, Tex.	26,398					1,[illegible]
	Laredo-Webb County Health Dept.	Laredo, Texas	318,749				X	9,[illegible]
	Southwest Migrant Association	San Antonio, Tex.	184,731	X		X	X	N/A
	Del Rio-Val Verde County Health Dept.	Del Rio, Tex.	60,224				X	7,[illegible]
	Deaf Smith County Public Health Clinic, Inc.	Hereford, Texas	86,494					1,[illegible]
	Oklahoma State Dept. of Health	Oklahoma City, Okla.	85,126	X			X	1,[illegible]
	De Leon Municipal Hospital	De Leon, Texas	74,992				X	N/A
	San Marcos-Hays County Health Dept.	San Marcos, Texas	50,764*			X		1,327
	Southern Mutual Help Association, Inc.	Abbeville, Louisiana	341,570				X	N/A
	Home Education Livelihood Program	Albuquerque, NMex.	404,895	X		X	X	N/A
	Hidalgo County Health Care, Corp.	Edinburg, Texas	657,944*	X		X	X	19,[illegible]
	San Patico Co. Commission on Youth Educ.	Sinton, Texas	427,372	X	X		X	14,632
	Coastal Bend Migrant Council	Corpus Christi, Tex.	234,958				X	7,551

*Awarded

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Region	Grantee	Location	Estimated Obligations FY 1974	Multi-Site	Mobile Clinics	Evening Hours	Dental Services	Physician Encounters
VII	Delmo Housing Corp	Lilbourn, Missouri	81,605*	X			X	N/A
	Nebraska State Health Dept.	Lincoln, Nebraska	115,903	X		X	X	3,050
	Kansas State Dept. of Health	Topeka, Kansas	189,529	X		x	X	1,224
	Muscatine Migrant Committee	Muscatine, Iowa	68,500*	X		X	X	1,229
	Migrant Action Program Inc.	Mason City, Iowa	62,563	X		X	X	1,200
	Los Cincos Pueblos, Inc.	Bonner Springs, Kansas	73,000			X	X	3,156
VIII	Colorado Dept. of Health	Denver, Colo.	255,107*	X		X	X	4,250
	Montana SDH & Environmental Sciences	Helena, Montana	45,000	X		X		870
	Plan de Salud del Valle, Inc.	Fort Lupton, Colo.	400,000			X	X	12,971
	Weld County Opportunity Agency	Greeley, Colorado	142,565*			X	X	3,694
	Utah Migrant Council, Inc.	Salt Lake City, Utah	214,728	X		X	X	3,635
	Northwestern Community Action Program of Wyoming, Inc.	Thermopolis, Wyoming	30,000	X		X		N/A
	Minnesota Migrant Health Service		20,000					N/A
	South Dakota		10,000					N/A
IX	Maricopa County Health Dept.	Phoenix, Arizona	295,000*	X	X		X	28,570
	Yuma County Health Dept.	Yuma, Arizona	169,000	X	X		X	2,635
	San Joaquin Medical Society	Stockton, Calif.	322,000*	X	X	X		N/A
	Stanislaus Medical Society	Modesto, Calif.	141,000*	X		X	X	6,039
	Kern County Health Committee	Lamont, Calif.	588,000*			X	X	N/A
	Orange Cove Family Health Center	Orange Cove, Calif.	767,894	X		X	X	7,525
	Clinica de Salubridad de Campesino's	Brawley, Calif.	719,000			X	X	4,053
	Arizona Job Colleges, Inc.	Casa Grande, Ariz.	286,000			X	X	12,971
	Merced General Hospital	Merced, Calif.	230,000*			X	X	6,996
	Riverside County Dept. of Public Health	Riverside, Calif.	59,703*				X	4,503
	San Luis Obispo County Health Dept.	San Luis Obispo, Calif.	141,000*			X	X	6,637
	Sutter County General Hospital	Yuba City, Calif.	77,403*			X	X	6,005
	Santa Cruz County Health Dept.	Santa Cruz, Calif	164,000*	X		X	X	5,915
	Regional Rural Health Program	Woodland, Calif.	365,000*	X		X	X	N/A

*Awarded

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[illegible]	Grantee	Location	Estimated Obligations FY 1974	Multi-Site	Mobile Clinics	Evening Hours	Dental Services	Physician Encounters
X	Oregon Dept. of Human Resources	Salem, Oregon	$ 30,000			X		N/A
	Farm Workers Family Health Center	Toppenish, Wash.	700,000	X	X	X	X	21,325
	Idaho Migrant Council, Inc.	Boise, Idaho	383,000	X		X		12,320
	North Central Washington Migrant Hlth.	Wenatchee, Wash.	211,000	X	[illegible]	[illegible]	[illegible]	[illegible]
	Whatcom Skagit Rural Opportunity Proj.	Mt. Vernon, Wash.	107,000	X		X		7,900
	Valley Migrant League	Salem, Oregon	452,300*	X		X		N/A
	Hospitalization Demonstration Program Lee County Health Dept, Ft. Myers, Fla. Catholic Charities, Inc., Harlingen, Texas Coastal Bend Migrant Council, Corpus Christi, Texas Plan de Salud del Valle, Inc., Ft. Lupton, Colo. Arizona Job Colleges, Casa Grande, Ariz. Whatcom-Skagit Rural Opportunity Council, Mt. Vernon, Wash.		3,002,000					
	1% Evaluation		237,500					
	TOTAL		$23,750,000					

*Award

Question. How many of the 103 projects offer dental services? How many more of the projects are capable of offering dental services but are not doing so? If the capability for providing dental care exists in other projects, why is this type of care not being provided?

Answer. Sixty-two projects offer dental services. In most cases, the dental services offered are of a limited nature (i.e., emergency care for relief of pain). All of the migrant health projects have the capability to offer dental services. Within the grant funds made available to a project, the project's policy board has the prerogative to determine health care priorities. In the case of those projects which do not offer dental services, their policy boards have not determined dental care to be a priority for expenditure of grant funds available to their projects.

Question. Do you regard accessibility of medical care to be a major objective of the migrant health program?

Answer. Yes. In order to be maximally effective in reaching migrant workers and families with health services, we have focused special attention on the maintenance of projects in areas where a significant number of migrants reside for a significant period of time. In addition to geographic accessibility, the problem is also addressed by program regulations which require "that all project elements will be provided in a manner calculated to preserve human dignity and to maximize acceptability and utilization of services."

Question. Do you have a method for measuring and comparing the cost effectiveness of the migrant health projects? If so, please describe it.

Answer. No. The migrant health program is currently implementing cost accounting and national reporting systems in migrant health projects. When these systems are in place, analysis of project utilization and cost data can be made to determine functional project costs and allow for comparison of these costs among migrant health projects.

Question. What is your policy on supporting with grant funds the cost of a medically equipped mobile van which would give the migrant worker greater accessibility to services?

Answer. Our policy is to view mobile vans as a sometimes useful for adjunct to the service delivery capacity of fixed location facilities. The use of mobile facilities involves certain considerations.

Their effective function requires good working relationships between the staffs of the mobile units and of the local practitioners and governmental officials.

Most experience indicates that it is faster (time saving) and more efficient to move staff in modern, rapid automobiles or airplanes to a local health facility rather than hamper travel by the cumbersome, slow moving trailer unit. Much valuable professional time is lost in transiting the mobile unit. Supplies are difficult to manage logistically and inclement weather adversely affects the mobility of units, particularly during winter months in mountainous terrain. The mobile unit concept presupposes adequate electric power for necessary dental or medical equipment, adequate sewage disposal and water supply and appropriate location within the community. These concerns seem more easily met with the *in locus* facility.

Few mobile clinic purchasers envision the necessity of eventually replacing the unit and few mobile clinic trailers have an expected life of more than 5 years. This adds a considerable amount to the yearly medical care cost. A $20,000 (small) mobile unit would add a cost of $4,000 per year, for the 5-year period of its usable life, to the basic cost of services and supplies. A further added cost in sums spent for *in locus* facilities would cover much more than rent only.

The nature of mobile units requires compactness and close spacing of services. In very few clinic arrangements is the necessity for waiting room space and dressing-undressing space recognized. This waiting room space would be nearly essential for conducting general practice activities.

Mobile units which proved successful have some characteristics in common:

(*a*) Services are generally limited or categorical rather than broad in nature (e.g., TB, VD, library, laboratory, etc.)

(*b*) Technicians and other less skilled personnel (paraprofessionals) are most commonly found manning mobile units. Highly trained health professionals prefer more stable surroundings in which to conduct their practices.

(*c*) Purchase of motor vehicle (truck) capable of hauling this mobile unit without harm to its vital working parts is an essential element to success. Normal production vehicles do not have this capability.

(*d*) Self-contained power units for air-conditioning in summer and heating during the winter expand the clinic's usability.

(*e*) Waiting room space adjacent to the mobile unit location also must be covered, air-conditioned, heated, and convenient to the mobile unit site.

Question. Has there been an evaluation by an outside group of the migrant health program? Please provide a copy of the evaluation report to the committee and provide a summary of the findings for the record.

Answer. The most current evaluation of migrant health activities was commissioned through contract by the Office of Secretary, HEW. Enclosed is a 30-page summary of the final report. The contractor was Community Change, Inc., Sausalito, Calif.

SUMMARY OF THE FINAL REPORT:

EVALUATION, DESIGN AND ANALYSIS OF MIGRANT HEALTH DELIVERY SYSTEMS

I. INTRODUCTION

A. Summary

The purpose of this study was to "provide: (a) a description of the effectiveness of the allocation of resources; (b) an analysis of alternative models of health delivery systems for migrants with indications as to which systems are most effective and feasible." The department phrased the problem in terms of a "basic question" of policy and resource allocation, "What kind of delivery system can be designed to provide comprehensive health care services to the largest number of migrant farm workers and their families within the present funding level and with specified additional funding?"

To answer the basic question, Community Change conducted a twelve-month study of the Migrant Health Program. The study included visits to 23 federally-funded migrant health projects in ten states, to ten state and regional offices, HSMHA headquarters, and to seven other programs offering models of migrant health care delivery (Final Report, pp. 175-178). In the course of the 41 site visits, the evaluation staff interviewed 781 project staff, program administrators, other health care providers, social service providers, migrant consumers, their advocates and elected public officials.

The study had four parts:

- evaluation of Migrant Health Projects;
- evaluation of state, regional and headquarters administration;
- projection of migrant health needs;
- analysis of alternative models for improving health care delivery.

B. Major Findings

The severely-limited migrant health funds are being used in an inefficient manner. They are spread so thin (over so many grantees) that they are ineffective and and fail to act as catalysts to generate other resources. Grants are not concentrated in locations of greatest need. The health care services provided are fragmented, intermittent and often of minimal quality. Grantees are predominantly local public health departments which are inappropriate in terms of program legislative objectives (direct primary care, continuity of care, consumer participation) and particularly incapable of creating new resources (attracting new physician manpower, creating new health care delivery mechanisms, innovating in the use of health paraprofessionals, maximizing third-party reimbursements).

C. Major Recommendations

The effectiveness of the migrant health program can be increased substantially within the present level of appropriation simply by concentrating program resources in a small number of large, comprehensive projects located in the areas of greatest need. This will entail the termination of most of the existing grants (those in low priority areas or providing low-priority services) and the systematic planning and technical support of new grantees in high impact areas.

This recommended program strategy would be easier to carry out in the context of expanding resources but can be implemented simply through the exercise of leadership and planning by the existing program administration. It will require a major modification of program style (previously highly personal and generally lacking a coherent strategy beyond merely distributing resources broadly) and a variety of difficult "political" decisions related to terminating grants, entry into priority areas, enforcing minimum program standards and stimulating Regional Office cooperation.

II. THE MIGRANT HEALTH PROBLEM

Migrant and seasonal farm workers and their families can be found throughout the country but are concentrated in ten states harvesting fruits and vegetables. The migrants travel from crop to crop to obtain work while seasonal workers remain in a single area. During periods of unemployment, migrant workers live in "home-base" areas in Texas, California, Florida and Mexico.

Migrant and seasonal workers both suffer from low wages, intermittant employment, lack of protective social legislation and ethnic and racial descrimination. Migrant workers additionally are excluded from programs such as welfare and medicaid (Title XIX) because they do not satisfy local residency requirements.

In 1970, there were nearly 2-1/2 million farm workers including 196,000 migrants[1]. Of the migrants, 63% are under 25 years of age and 82% are male. Less than a third of the migrant workers are heads of household. The average migrant obtained a total of 133 days work in 1970 and earned an annual income of $1930. This includes 88 days of farm work and 45 days of non-farm employment.

The health problems of migrants and seasonal farm workers are similar to other economically disadvantaged sectors of the population but aggravated by legislative exclusion, mobility, and location in medically underserved rural areas.

A. Numbers and location of migrants

Department of Labor statistics show that migrant employment is concentrated in ten states which, at the peak, each have more than 10,000 working migrants. (See Table I, page 4.)

Within these states the demand for migrant labor is highly variable and subject to seasonal fluctuations. In some states such as California, there is a continual demand for migrant labor, ranging from a low of 11,000 in February to a high of 55,400 in September. In other states such as Michigan, there is no employment for migrants in the months from December to March, but high demand for migrants from June to September.

Employment statistics do not include non-working dependents of migrants and fail to reflect the numbers of unemployed migrants in home-base settings. According to state agencies, the vast majority of home-based migrants are concentrated in three states[2]. (See Table II, page 4.)

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[1] Economic Research Service, USDA, The Hired Farm Working Force of 1970.

[2] Final Report, pp. 20-21.

TABLE I

PEAK EMPLOYMENT BY MONTH OF MIGRANT WORKERS AND MAN/MONTHS OF SEASONAL WORK, 1970

STATE	PEAK MONTHLY EMPLOYMENT	PEAK MONTH OF EMPLOYMENT	MAN/MONTHS OF SEASONAL WORK (thousands)
California	55,400	September	1,356
Michigan	28,900	July	183
Texas	19,800	July	1,066
Florida	16,700	January	655
Ohio	16,600	September	123
New York	12,000	September	81
New Jersey	11,500	August	83
Oregon	11,300	June	207
Washington	10,900	September	256
North Carolina	10,600	August	849

Source: U.S. Department of Labor, Manpower Administration, "In Season Farm Labor Reports, 1970."

TABLE II

TOTAL MIGRANTS AND DEPENDENTS IN THREE HOME-BASE STATES

Florida	87,170
Texas	111,267
California	114,930
Total	313,367

Using a combination of residence and employment data, it is possible to identify 59 counties in 15 states which have migrant populations of 4,000 or more[1]. These migrant impact settings include resident migrants who migrate to other areas for employment (home-base areas), areas with relatively few resident migrants (upstream areas) and areas which have a mixed character composed of both resident and in-migrant workers.

The population to be served, migrants, seasonals, and dependents, in these 59 impact settings range from 4,000 to 56,000 people. These locations are either single or adjacent counties.

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[1] *Final Report*, pp. 203-207.

TABLE III

DISTRIBUTION OF MIGRANT IMPACT AREAS BY NUMBER OF MIGRANTS AND TYPE OF SETTING

TOTAL MIGRANTS AND DEPENDENTS	TYPE OF SETTING			
	HOME-BASE	MIXED	UPSTREAM	TOTAL
4,000-7,999	12	5	11	28
8,000-11,999	6	5	4	15
12,000-23,999	1	9	0	10
24,000-plus	2	2	2	6
Totals	21	21	17	59

B. Medical Resources in Migrant Areas

Existing medical resources in the 59 migrant impact settings are generally inadequate in comparison to national averages. Of the 59 settings, 53 have less primary care physicians than the national average (1:1635) and 22 have less than the national rural average (1:2510)[1].

TABLE IV

EXISTING MEDICAL RESOURCES IN MIGRANT IMPACT SETTINGS

RECEIVING RESOURCES	HOME-BASE	MIXED	UPSTREAM	TOTAL
Adequate	0	5	1	6
Substandard	11	13	7	31
Critical	10	3	9	22
Totals	21	21	17	59

source: Distribution of Physicians, Hospitals and Hospital Beds in the U.S., 1969, Volumes I and II, American Medical Association, 1970.

The migrant impact settings are also generally poorer and more rural than the national average although seven of the 59 are in urban areas with populations exceeding 500,000. When the adequacy of the receiving health system is contrasted to the type of migrant setting, it is obvious that the most severe problems exist in the 21 home-base settings of which eleven are substandard and ten are critical.

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[1] American Medical Association, op. cit.

TABLE V

MIGRANT IMPACT SETTINGS BY TYPE, RURALITY AND ADEQUACY OF THE HEALTH SYSTEM

	HOME		UPSTREAM DURATION		
Rural:	BASE	MIXED	MEDIUM	BRIEF	TOTAL
Adequate	0	1	0	0	1
Substandard	4	5	2	2	13
Critical	7	2	7	1	17
Non-Rural:					
Adequate	0	4	1	0	5
Substandard	7	8	2	1	18
Critical	3	1	1	0	5
Totals	21	21	13	4	59

source: American Medical Association, op. cit.

In summary, of fifty-nine migrant impact settings, 88% are either rural or small metropolitan, 90% have less-than-adequate existing health resources, and 71% require programming for eight months or more.

C. Trends in migrant labor

The number of migrant farm workers is constantly decreasing but at a rate which is less rapid than the decline in all farm workers. As a result, the migrant portion of the labor force has increased in three of the past four years. This trend results from the increasing industrialization of agriculture and the decline in family farms. Thus, within the farm work force, the major declines have come in the area of family workers, and these declines have been much faster than among hired farm workers.

In addition to economies of scale, the industrialization of agriculture requires increased mechanization and specialization. These have opposite effects on the need for migrant labor. Mechanization attempts to reduce all labor needs by replacing men with machines. At the same time, specialization is creating high but brief labor demand. As a result, the trend reflects competing tendencies in the agricultural labor market which partially cancel each other.

Demand for migrant workers is concentrated in a relatively small number of crops and crop activities. Mechanization, to reduce migrant demand, must focus on these activities. While agricultural mechanization has proceeded rapidly in some activities, it has

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[1] Velmar W. Davis, "The Demand for Fruit and Vegetable Labor in 1975," *Farm Labor Developments*, April/May, 1970.

also neglected others. There are many areas of high labor demand where mechanization has had little impact and there is little prospect that it will do so in the immediate future. For example, one expert forecasts a 41% increase in orange production between 1968 and 1975 with only limited improvement in labor efficiency which will result in a 24% increase in labor demand.[1]

The same expert has estimated the progress of mechanization in fruit and vegetable crops in 1975. He expects limited mechanization of fruit harvests (from 2% in 1968 to 17% in 1975) and continued mechanization of vegetables (from 56% in 1968 to 75% in 1975).[1] The result of this mechanization will be a 12% decline in agricultural labor requirements.

Just as the reports on mechanization are often overly optimistic, there is a similar tendency to assume that, when faced with low wages and declining employment, migrants will move out of farm work and into other occupations. But it is obvious that there is a strong tendency for migrants to remain in farm work, or at least consider farm work, in spite of very unattractive working conditions and low wages.

This tendency results from the limited occupational mobility of migrants and the inefficient nature of the agricultural labor market. Migrants are frequently uneducated, immigrants and young. They generally lack skills necessary for regular employment outside agriculture. Inefficiencies in the labor market and the seasonality of labor demand suggest that a reduction in aggregate labor requirements will not immediately result in a parallel adjustment in labor supply.

The number of migrants is declining, but more slowly than in other areas of farm labor. This is because specialization and mechanization to some extent work against each other. The first creates areas of high labor demand while the second reduces this demand through the introduction of machines. Additionally, mechanization has not yet really affected some crops, for example citrus and strawberries, in which the labor demand is very high.

Finally, it is probably incorrect to assume that further mechanization will immediately result in fewer migrant farm workers. Because of their limited occupational mobility, many of these workers will probably remain in agriculture and face lower annual incomes.

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[1] Velmar W. Davis, *op. cit.*

III. PROGRAM BACKGROUND

A. Legislation

The Migrant Health Act (PL 87-692), enacted in 1962, added Section 310 to the Public Health Service Act authorizing HEW to make grants to public and other non-profit agencies, institutions and organizations to pay part of the cost of, "establishing and operating family health service clinics for domestic agricultural migratory workers and their families." The act has since been amended to authorize hospital care (1965) and to require consumer participation (1970). The 1970 amendments also broadened the definition of migrants to include seasonal farm workers and their families.

The act currently has budget and program authority through June 30, 1973.

B. Appropriation History

The first appropriation under the act was made in 1963. The current (F.Y. 1970) appropriation is $15 million.

TABLE VI

AUTHORIZATION AND APPROPRIATION HISTORY
MIGRANT HEALTH PROGRAM
Fiscal Years: 1962 - 1970

YEAR	AUTHORIZATION (000's)	APPROPRIATION (000's)	TOTAL MIGRANTS (000's)[1,2]	AMOUNT AVAILABLE PER MIGRANT[3]
1962	None	None	386	None
1963	$ 3,000	$ 750	386	.97
1964	3,000	1,500	386	1.93
1965	3,000	2,500	466	2.68
1966	7,000	3,000	351	4.27
1967	8,000	7,200	276	13.04
1968	9,000	7,200	279	12.90
1969	9,000	7,200	257	14.00
1970	15,000	15,000	2,488	3.01

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[1] Source: Annual Reports, Economic Research Service, USDA, The Hired Farm Working Force of 1962-1970.

[2] Legislative Amendment broadened eligibility to include seasonal farm workers effective 1970.

[3] The per capita total is based on the assumption that there is one non-working dependent for each working migrant and seasonal farm worker.

The appropriation increased by $7.9 million in 1970 (an increase of 108% over the 1967-1969 program level), but the amendment which expanded the eligible population to include seasonal farm workers resulted in a dilution of per capita appropriations from $14 to $3.01.

C. Current Program

The original program strategy was to spread the limited resources across a relatively large number of small projects hoping to divert existing programs into serving migrants.

Small grants were made to public health departments to expand services to migrants and to local "migrant committees." The 1970 amendments and appropriation increase allowed for a modification of this approach. New grant funds were concentrated in fewer projects offering relatively more comprehensive care. Seven large new grants were made to projects with consumer participation and offering comprehensive ambulatory care. Several existing grantees were awarded expanded grants to carry out the broadened mandate and a few smaller projects were phased out.

TABLE VII

DISTRIBUTION OF MIGRANT HEALTH PROJECT GRANTS BY DOLLAR AMOUNT

GRANT RANGE	NUMBER OF GRANTS	% OF TOTAL GRANTS
$0-$30,000	45	29
$30,000-$60,000	48	30
$60,000-$120,000	26	17
$120,000+	38	24

As Table VII demonstrates, even after the appropriations increase and broadened mandate, 59% of the project grants are for $60,000 or less. As Table VIII shows, grants to state and local government account for 71% of the projects and 67% of the funds. Although the 1970 grant awards were larger than in previous years, the program continues to consist of a relatively large number of small projects.

D. Administration

The Migrant Health Program is administered by a Migrant Health Branch within the Community Health Service (CHS) of the Health Services and Mental Health Administration (HSMHA) of HEW. Projects are operated by a variety of public and non-profit agencies on annual project grants administered by CHS staff in the ten HEW Regional Offices.

In most of the states with high migrant impact, the state health agency has a grant to provide administrative support and technical consultation to local project grantees. In several states (e.g., California and Florida), the state also acts as an intermediary grantee which contracts with local health departments for the delivery of direct services to migrants.

TABLE VIII

DISTRIBUTION OF PROJECTS AND FUNDS BY TYPE OF SPONSORSHIP

PE OF SPONSOR	TOTAL NUMBER OF PROJECTS	PERCENT OF TOTAL PROJECTS	TOTAL AMOUNT OF GRANTS	PERCENT OF GRANT FUNDS	AVERAGE GRANT
ate Health Department	21	13%	$ 2,588,032	17%	$ 123,250
cal Health Department	80	51%	6,844,224	46%	84,578
her Local Government	11	7%	518,016	4%	47,092
dical Society	7	4%	531,995	4%	75,999
iversity (Medical School)	3	2%	518,257	4%	172,752
spitals	3	2%	136,546	1%	45,515
luntary Agency	26	17%	1,221,947	8%	46,998
nsumer-based Organization	6	4%	2,401,189	16%	400,198
Totals	157	100%	$14,760,206	100%	

urce: List of Grantees, Migrant Health Branch, August, 1970

IV. STUDY METHODOLOGY

The study was designed to identify that model or group of models of health care delivery which would be most appropriate in terms of the health needs of migrants, most efficient in the context of the severely limited resources and most likely to provide basic health care to the largest number of migrant and seasonal farm workers and their families. The study used four separate approaches:

1. evaluation visits to 23 migrant health projects;
2. administration visits to five state agencies, five HEW Regions and the Migrant Health Branch in Washington;
3. analysis of existing data on migrants, agricultural employment, mechanization and physician supply;
4. analysis of a variety of alternative health delivery models and visits to seven programs offering potentially applicable models or components.

A. Site Selection

Projects to be visited were selected to serve two purposes. They were to provide a representative sample of the nature and effectiveness of the existing program and to offer a variety of empirically-based models of alternative health delivery systems for migrants.

TABLE IX

MIGRANT HEALTH PROGRAM
PROFILE AND GRANTEES VISITED[1]

SPONSORSHIP	TOTAL PROJECTS	PROJECTS VISITED[2]
State Health Department	21	6
Local Health Department	80	11
Other Local Government	11	1
Medical School	3	2
Hospital	3	1
Medical Society	7	3
Voluntary Agency	26	0
Consumer-Based Organization	6	4
TOTAL	157	28

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[1] Source: List of Grantees, Migrant Health Branch, August, 1970

[2] Includes five state programs and 23 project grantees.

The project sites selected are representative of the program universe in terms of:

- types of migrant settings
- relative impact of migrants
- alternative project models
- types of project sponsorship

The evaluation visits included 10 of the 33 states in which there are migrant health grants and projects totalling 29% of the current program funds.

B. Site evaluation approach

The 23 project evaluations were conducted by interdisciplinary teams composed of three of more people. The evaluation staff included health professionals, community organization specialists including former migrants and public administration experts. A physician participated on eighteen of the twenty-three project site evaluation teams.

Each site evaluation included interviews with project staff, migrant consumers of project services, public officials, other health providers and staff of other social service programs potentially serving migrants. Each project was evaluated in terms of its internal performance, the appropriateness of the program model to the program setting and the extent of linkage with the existing health and social service delivery systems.

C. Projection of migrant needs

The projection of trends in migrant health needs are based on a thorough search of published data including particularly the annual migrant census of the Department of Agriculture, employment data from the Department of Labor, health resource data from the American Medical Association and projections of trends in agricultural economics and technology from a variety of sources. Current estimates of migrant and seasonal farm worker population were obtained from state agencies in the five states of highest migrant impact.

D. Modeling alternative health delivery systems

The analysis of alternative models of health delivery was based on models and program elements drawn from a variety of sources. Existing Migrant Health projects provided a set of empirically-derived models. Visits to seven other programs provided additional alternatives including pre-paid health insurance, direct federal administration and closed panel, pre-paid group practice. Other models and variations were suggested by the 781 people interviewed in the course of the study.

The models were analyzed and compared in terms of appropriateness to migrant settings and relative capacity to provide minimum adequate ambulatory care in the most efficient fashion.

V. FINDINGS

A. Existing project models

All twenty-three projects visited can be classified into one of three models. These models class the projects by the scope and nature of the services available. These three empirical models describe the full range of existing migrant health services.

1. Preventive Emphasis Model

Preventive emphasis projects limit direct service to preventive and screening activities. Such projects are generally small, sponsored by local health departments and a product of the early program strategy of using small investments to expand existing services to migrants.

Frequently, the Migrant Health grant does not pay the salary of an identified employee, but rather increases the staffing level of the agency with the understanding that all staff members will have some migrant responsibilities.

2. Intermittent Care Model

The most common model offers diagnosis and treatment of general disease processes through the use of employed part-time physicians in field and night clinics. The typical project is located in temporary facilities in a farm labor camp, school or church and is open one or two nights each week during the migrant season. This model provides increased accessibility and expanded services over the preventive emphasis model.

Clinic quality is frequently limited by the inadequacy of equipment and ancillary support particularly in terms of x-ray, laboratory and drugs. The intermittent care project usually has limited access to specialty diagnostic and treatment services in and out of the hospital.

3. Comprehensive ambulatory care model

A small number of recently-funded projects offer general family medical services through the use of full-time salaried physicians practicing in small groups. Such projects offer a wide range of ambulatory diagnosis and treatment of disease and usually have some funds to purchase specialty diagnostic and treatment services. The comprehensive ambulatory care projects frequently have no grant funds for hospitalization.

Comprehensive projects visited were generally newer and larger than the other two models of limited scope. The comprehensive projects also frequently were sponsored by non-profit agencies with significant consumer participation and tended to be located in areas of high and long-duration migrant impact. Such projects frequently served consumers who were predominantly seasonal rather than migrant farm workers.

TABLE X

DISTRIBUTION OF MIGRANT HEALTH PROJECTS
VISITED BY SPONSORSHIP AND TYPE OF MODEL

SPONSOR	TOTAL	PREVENTIVE EMPHASIS	INTERMITTENT CARE	COMPREHENSIVE AMBULATORY
State Health Dept.	1	-	1	-
Local Health Dept.	11	4	6	1
Other Local Govt.	1	-	1	-
Medical Society	3	1	2	-
Medical School	2	-	2	-
Hospital	1	-	1	-
Consumer-based	4	-	-	4
TOTAL	23	5	13	5

As the above table shows, projects sponsored by public agencies tend toward a less comprehensive scope of service while all consumer sponsored projects visited used a comprehensive service model.

B. Evaluation of services and operational characteristics

1. Preventive health

All twenty-three projects offer preventive health services. In eighteen, these services are in a general clinic setting. Ten projects support staff sanitarians and eleven have preventive health staff (public health nurses, health educators, nutritionists, social workers and aides) who are not based in a clinical setting.

The extent and nature of preventive health services correlates highly with project sponsorship. Projects administered by health departments place a higher emphasis on indirect services (those not related to personal health care) and categorical services. The ten projects paying salaries of environmental sanitarians are all public health departments. None of the four consumer-based projects includes sanitation services. Limited service clinics (those without a physician present or with categorical services) are also characteristic of health department sponsorship. All ten projects offering categorical clinics and seven of the eight clinics without physicians are under health department sponsorship.

It has been the Migrant Health Program strategy that investment of grant funds in local public health departments would extend traditional services to migrants. The visits to projects sponsored by state and local public health departments suggest that frequently the grant funds support the on-going activities of the department without significantly increasing services to migrants. Of the ten projects paying for sanitarians (all with health department sponsorship), nine appear to be using them for substantial non-migrant work.

Other projects use migrant funds to support basic health department services. One six-week migrant project was staffed with a year-round health educator. In one project with no migrant-funded sanitarians, the project paid for $12,000 worth of radio equipment for sanitarians. Another project simply paid the salaries of indigenous aides to staff the on-going health department clinics. Of thirteen projects of varying sponsorship which provided services only during six-weeks to six-month migrant seasons, six had one or more staff people paid year-round. The six projects accounted for fifteen year-round staff positions.

2. Ambulatory diagnosis and treatment

Primary medical care varies in the three empirical models from none (the preventive-emphasis projects) through intermittent to continuous ambulatory care in a single setting. Only five of the twenty-three projects offer continuous services. The five all have salaried staff physicians who are, with one exception, working in a group practice setting. Four of the five projects are sponsored by consumer-based organizations and the fifth by a local health department.

The five projects which offer continuous care are the only ones of the twenty-three visited which have actually increased the supply of physicians available to serve migrants. All five projects have attracted physicians from outside the area. The intermittent care projects usually rely on local private physicians who volunteer (for pay) to work in the migrant clinics. Such arrangements do not increase the aggregate number of physicians, but only the hours they work.

3. Specialty referral

Fifteen of the twenty-three projects visited had a fund to pay fee-for-service costs of specialty referral. This included projects which had no other medical resource and used the fee-for-service referral to buy routine care. Such referral funds were frequently inaccessible and quickly exhausted. Other projects limited the referral funds to acute illness or to certain ages and sexes. One project even limited the referral to residents of certain labor camps while excluding migrants living in other camps nearby.

The fee-for-service funds in the primary-emphasis projects were often misused. Either they were quickly exhausted or they were misered for the most acute and desperate patients. In neither case could they be used effectively to purchase specialty care since there was no primary care.

In the intermittent care model, the referral fund was used for specialty care but also for routine diagnosis and treatment which was not possible in the clinic. If the clinic was not to be opened again for a week, the physician would refer out acute illness so that the diagnosis could be completed and treatment begun before the following week.

The four consumer-based, ambulatory care projects had small specialty referral funds which were used efficiently for specialty care after primary encounters with the staff physicians.

4. Hospitalization

Hospitalization of migrants, because of its costs, was a problem in all projects visited. To control costs, Migrant Health policy has been to force grantees to use other resources for hospitalization. Of the 23 projects visited, five had token grant funds for hospitalization. Of these, two used small amounts of money to match or generate funds from other sources.

Seven projects used a variety of ingenious but awkward schemes to get their patients into hospitals. These included three projects which referred patients to medical school teaching hospitals fifty miles from the clinic site. New Jersey and Michigan projects used state programs to pay migrant hospitalization. Two projects, one sponsored by a hospital, used local indigent funds to pay hospital costs. Fifteen projects had no particular hospitalization scheme although some attempted to use local indigent hospitals on Title XIX.

Except for South Texas, where the supply of hospital beds is inadequate, the migrant hospital problem is largely one of financing. One Michigan project, using a combination of project advocacy and state financing, has resolved the problem. The other projects have used a variety of ineffective or inconvenient make-shift approaches with spotty success.

National hospital programs for indigents fail to serve migrants. Hill-Burton facilities at two project sites refused migrant patients and forced them to travel forty-five miles to urban teaching hospitals. Medicaid was an available hospitalization resource for a limited number of migrants due to strict interpretation of requirements of "intent to reside." In California, unemployed home-based migrants and seasonals can sometimes qualify for welfare if they have dependent children. In the other states, Medicaid is simply not available to migrants. In no state is it available to a working migrant.

5. Operational Characteristics

The three empirically-derived models all exhibit some deficiencies in performance.

a. Adequacy of Scale

Of the 23 projects visited, only one was clearly excessive in scale. The others were all inadequate to some extent. There was no correlation of scale and sponsorship or setting except that the downstream projects appeared to be more grossly deficient in scale than other sites. The limited scale of most projects not only resulted in unmet needs, but also an inability to deliver the scope of services necessary to achieve minimum standards of comprehensiveness. Only the largest grants, over $200,000, were able to provide basic lab and x-ray services. The small-scale projects, without exception, failed to realize economies (use of third-party payments, use of paraprofessionals, quality and utilization control) because they could not release the staff necessary to plan and implement such systems.

b. Accessibility and Acceptability

Project accessibility directly correlated with the scope of service and the size of grant. The preventive-emphasis projects tend to be inaccessible because they are fragmented by location, by category of service and by time. Projects seldom had adequate patient support (transportation, translation, etc.) and had no formal consumer participation.

Intermittent care projects have increased accessibility because they are usually located in labor camps or public buildings in migrant areas. The accessibility they gain by location, they lose by the intermittent nature of their services. One such project, excellent in terms of service and organization, disappeared so completely that even project aides could not explain how to contact the project between weekly clinic sessions. Such intermittent clinics are of limited value as points of access into the larger health system. Acute conditions are particularly unserved by the intermittent care model.

The five comprehensive ambulatory models offered much greater access than the other projects. Although services were less decentralized than in the intermittent care model, the comprehensive projects compensate by having improved patient support, convenient hours and continuous service.

Consumer participation in intermittent care projects ranges from none to advisory groups which meet occasionally with vague responsibilities. Of the 13 intermittent care projects, five claimed organized consumer participation. Of the five comprehensive ambulatory projects, four have active consumer participation at a policy level. The fifth, sponsored by a local health department, had no organized consumer participation at the time of the site visit.

c. Efficiency

Continuity of care only exists in the comprehensive ambulatory model. The smaller projects are fragmented and usually too small to have adequate records. Continuity of service among projects, along the migrant "stream," is not effectively present in any model. Quality monitoring and utilization control are limited in all but the comprehensive ambulatory care models.

The single factor which correlates highest with project efficiency is size. The smaller projects are unable and often unwilling to add frills such as systems for billing third-party payment sources. Health department policy often precludes billing third parties although they may have provided services reimbursable by workmen's compensation insurance, Puerto Rican Contract Workers insurance, Kennedy (Union) Medical Plan or private health insurance. Health departments are often ineligible to be vendors for Medicaid and Medicare.

Health manpower utilization is a potential source of economies, yet none of the 23 projects visited are successfully using non-physicians in expanded roles. Models of manpower innovation were observed in other programs (Salud clinic, Colorado Nurse Practitioner, Rural Health Project) which could be used in migrant projects.

One project was using aides as clinic supervisors and another was using nurses in slightly expanded roles. Many of the health department projects did not even use paraprofessionals for patient support (interpretation, baby-sitting, transportation). In general, health department sponsors were least open to developing paraprofessionals while the consumer projects were dedicated to innovation in manpower utilization.

Analysis of budgets of sixteen of the projects visited showed that ten health departments devoted 33% of their migrant grants to direct patient service while six other sponsors allocated 51% of their budgets to such services. This largely reflects the commitment of health departments to indirect (i.e., non-clinical) services but also suggests that health departments are inappropriate sponsors for a program offering direct primary care.

Summary

Field observation suggests that size and sponsorship are critical variables in determining project effectiveness. Only the largest projects (exceeding $200,000 annually) demonstrate a capacity to attract new physician manpower, generate third-party reimbursements, make innovative use of paraprofessional personnel , involve consumers and offer comprehensive health care. In general, the projects with these desirable characteristics were sponsored by organizations which included migrant consumers in a policy role. Direct service projects sponsored by state and local health departments seldom are as large as the consumer-based grants and rarely have any of these characteristics of project effectiveness. The one large health department project visited ($423,000) had most of the characteristics of the large consumer grants except for consumer involvement. The other health department projects showed occasional use of staff in non-migrant activities.

C. Administration

Any modification of migrant health policy or program strategy will require administrative action at the headquarters, regional or state level. The site visits to the three administrative levels point out a limited capacity for program change.

At the headquarters level, the program is severely understaffed, bureaucratically submerged and unable to exert program leadership. Until the general HEW decentralization of 1970, the program had been administered from headquarters with Regional Migrant Representatives merely providing liaison. With the decentralization, the Regions were given all program development, project review and administration. Headquarters retained responsibility for policy development, fund allocation among Regions, data collection, evaluation, training and monitoring Regional program effectiveness.

The reorganization assumed both central policy and adequate Regional staffing, neither of which exists. For eight years the program could function without policy regulations because it was small and centrally administered. The program had been attempting to prepare guidelines since 1967, but had been unable to exert the sustained leadership necessary to establish policy. The branch also suffered from recurring reorganization and threat of reorganization which stifled progress.

Decentralization of authority to the Regions forced the headquarters staff into the unfamiliar policy role, if only to control project decisions by establishing program parameters. When guidelines are issued, the implementation and compliance responsibility will rest with the HEW Regional Offices. Visits to five Regional Offices found them inadequately staffed in terms of numbers and skills. Regional staff also, because they are closer to the projects than headquarters, tend to reflect the attitudes and problems of the local projects. For lack of clear guidance, staff in the five Regional Offices visited had very different policies and priorities. No two were alike except that two were generally not sympathetic to the draft regulations which had been circulated.

The state health agencies visited proved to be even more inflexible and resistant to change. They are institutionally married to local health departments so that only such agencies receive their project development and consultation services. The consultation capacity of the states is limited to traditional public health disciplines (environmental sanitation, health education, nutrition, etc.) and neglect the current program priorities (health care delivery and consumer participation).

The states are not currently capable of providing consultation in priority project activites. They are committed to one type of project sponsor and to low priority program activities. The states are antagonistic to the new guidelines.

In summary, the leadership for program improvement must come from headquarters in the form of new guidelines and a coherent program policy. In addition, headquarters must develop a system to monitor and enforce its policy on the Regions and to provide the Regions with the technical support and field staff they currently need. State programs should be terminated except as they develop capabilities consistent with program policy and priorities.

VI. RECOMMENDATIONS

The following recommendations summarize the findings from the field visits, data analysis and modeling of alternative migrant health delivery systems. Only two of the 26 recommendations require additional appropriations. Within the existing level of appropriation ($15 million annually), it is possible to improve the effectiveness of the program by increasing primary care, concentrating resources and generating third-party payments, particularly from Title XIX.

A. Program Recommendations

The progress of agricultural mechanization will continue to reduce the need for farm labor over the next five years but will not eliminate it entirely. The 2-1/2 million farm workers, including 196,000 migrants, are likely to continue to work in agriculture and to live in medically underserved areas. Because of their occupation, mobility and seasonal employment, these farm workers have traditionally been the last group to benefit from broad programs of social service and assistance. For example, farm workers continue to have limited Social Security coverage and, with few exceptions, do not benefit from Medicaid.

Appropriations

As the appropriations history shows, the program has never had more than $14 to spend on each migrant and currently has $3.01 to spend on each migrant, seasonal worker and dependent. This expenditure compares with the $294 which the Indian Health Service spends annually to deliver comprehensive health service to each Indian.

An annual increase of $10 million will enable the program to add 15 new comprehensive projects annually and to provide comprehensive services to all migrants in concentrations of 4,000 or more by fiscal 1975.

To continue to provide minimum health services to migrants, it is recommended that:

- THE MIGRANT HEALTH PROGRAM APPROPRIATION BE INCREASED AT THE RATE OF $10 MILLION ANNUALLY FOR EACH OF THE NEXT FIVE YEARS.
- THE MIGRANT HEALTH PROGRAM BE ADMINISTRATIVELY CONTINUED AS A NATIONAL CATEGORICAL PROGRAM.

B. Recommended Program Strategy

The cost of adequate comprehensive health care for the estimated 5 million seasonal and migrant farm workers and their dependents would total $1.5 million which is 100 times the current appropriation. The recommended strategy assumes that there is no possibility of adequate appropriations and, consequently, program resources must be invested in a limited number of settings of greatest need.

The strategy which emerges from the analysis of alternative models of migrant health care delivery is one which places the greatest emphasis on the creation of a health delivery system in those locations which have the most migrants for the longest period of time: home-base settings. In addition, smaller amounts of money should be used to create access to existing health care for migrants in upstream settings.

The purpose of the concentration of resources is to create health systems of such scale that they can provide comprehensive ambulatory care and can act as catalysts to generate other resources. The field observations pointed out that only the larger projects demonstrated efficient manpower utilization, success in attracting physicians, consumer participation and third-party reimbursements. The smaller projects were frequently inefficient, ineffective, and provided fragmented or inadequate services. By concentrating resources into fewer, more comprehensive projects, the strategy simplifies the federal administrative burden by reducing the total number of grantee units and increasing the project management capability. The concentration of resources is also an attempt to achieve critical mass scale in selected impact areas both to generate outside resources and to create systems which can benefit from any new legislation which finances, organizes or staffs indigent health care. All the health legislation currently proposed requires some existing health infrastructure at the local level. The program strategy is designed to create that structure in the settings of highest migrant impact so that migrants can be assured the benefits of new legislation.

The consequences of this recommended strategy are that existing projects which do not conform, in terms of setting or model, will have to be terminated and the grant funds transferred to conforming settings and projects. As new appropriations become available, they will also be invested in the impact settings.

Migrant Settings

Migrant and seasonal farm workers can be found in 900 counties in 46 states. In 59 of these counties, migrants and dependents total 4,000 or more at some time during the year. Another 200 counties have 1,000 or more migrants. Within the current appropriation and administrative capacity of the program, it is necessary to concentrate resources in those 59 settings of greatest migrant impact. Of the 59 migrant impact settings, 42 have long duration migrant presence. Of these 42 long-duration settings:

- 21 are home-base
- 21 are mixed
- 37 have inadequate existing health systems
- 19 are rural

Short duration settings include the 17 upstream sites and the 21 mixed sites which share the characteristics of both home-base and upstream settings. Project scale will vary since the number of migrants at the impact settings ranges from 4,000 to 56,000. The

59 migrant impact settings will require 95 permanent projects and 32 seasonal projects in upstream settings. The total estimated cost of this strategy is \$45.6 million[1]. Of this total, \$31.6 million will be invested in home-base settings and \$14.0 in upstream settings. The total cost is three times the current level of appropriation. If the appropriation increases, as recommended, at an annual rate of \$10 million, the recommended strategy can be carried out by the end of 1975.

Program Models

The recommended program strategy requires two basic models for migrant impact settings. For home-base and the long-duration portion of mixed settings, the recommended project form is the comprehensive ambulatory model which is a system creation model. For short-duration settings, upstream and the short-duration portion of mixed settings, the appropriate model is one which concentrates on creating access into the existing health system.

The purpose of both models is to deliver minimum adequate comprehensive primary care in a manner appropriate to the setting. This requires that each project have a capacity to:

a) deliver primary ambulatory health care

b) provide patient support including transportation, translation and other support as necessary

c) guarantee hospital access for emergencies, obstetrics, and other in-patient services

d) provide specialty referral and necessary follow-up services to guarantee continuity of care

e) generate third-party payment and reimbursements from Medicaid, Medicare, Workmen's Compensation and other insurance sources

f) provide for consumer participation

g) link clients into other social services (e.g., Food Stamps, legal services, migrant education, etc.)

h) utilize health paraprofessionals in training and career development roles.

Components guaranteeing access to dental services, mental health and rehabilitation should not be required as a condition of funding, but are strongly recommended.

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[1] Final Report, p. 157.

Implications of the Strategy

The concentration of resources in migrant impact settings and the development of minimum standards of comprehensiveness will require the termination of non-conforming grants. Currently, 43% of the total appropriation ($6.4 million) is invested in areas that are not among the 59 impact settings. These 105 projects will have to be reviewed. Except for those in medium-impact upstream settings (1,000 - 4,000 migrants for 4 to 8 months), the projects should be phased out and the funds transferred to high-impact settings. Small grants, those under $60,000 per year, will have to be terminated or expanded to meet minimum standards of scale and comprehensiveness. Currently, 59% of the projects are smaller than $60,000.

Inappropriate project models exist in both impact settings and non-impact settings. Of the existing models, all preventive-emphasis projects should be phased out immediately. Preventive-emphasis projects located in impact settings should convert to more appropriate models or be phased out. Intermittent care projects should be examined and indirect service components (health education, environmental sanitation, nutrition and detached public health nursing) should be terminated. If the project is located in an impact setting, it should be expanded and modified as necessary. Comprehensive ambulatory projects should be reviewed to determine if they require additional funds or components to meet the scale demands of their setting.

In summary, all projects will have to be reviewed to ensure that they are located in an impact setting, are using a program model which is appropriate to the setting and are meeting minimum standards of comprehensiveness. Projects which do not meet these criteria will have to be terminated.

Administration of the Recommended Strategy

The recommended strategy will require several major modifications in the administration of the migrant health program. These modifications include publication of policy regulations, planning to implement the regulations, headquarters leadership and a vastly reduced role for state agencies.

It is imperative that policy guidelines be published promptly. Decentralization of project authority to the Regions forced headquarters to issue policy as guidance and to enforce compliance with legislative intent, law and agency policy. As demonstrated by the past year, the program is going to remain inert until guidelines are published. The immediate publication of program guidelines is a necessary precondition of any program improvement.

The branch will have to set priorities among unserved and underserved migrant impact settings and concentrate project development activities in those areas. Planning grants, supported by consultation and technical assistance, will be necessary to enable potential migrant grantees to organize consumer participation and develop a grant application.

The need for program leadership will be most evident in the relations between headquarters and the regions. The regions, because they have been administering projects for a year without formal policy guidance, can be expeted to resist any change which is centrally initiated. The guidelines are likely to be a source of conflict even before any implementation plan is developed. Implementation plans, unless they contain incentives for regional effort and compliance, are likely to be ignored.

Twenty-one state health agencies are currently receiving project grants to act as intermediaries with local rpojects or to provide supporting services to local projects. The state grantees are predominantly committed to supporting low priority components, local health department sponsors and obsolete project medels. State consultation skills are concentrated in environmental sanitation, public health nursing and health education with virtually no consultation capability in health care organization and delivery.

All state grants should be reviewed. Those which play intermediary administrative roles should be terminated. State consultation should only be supported insofar as it is supporting projects in priority activities such as organization of care, consumer participation, New Careers development and project grant administration. The states can be valuable sources of technical assistance and potentially of resources if they are willing to support the new program strategy. If not, the state grants should be terminated.

To carry out the program strategy, it is recommended that:

- THE MIGRANT HEALTH PROGRAM BE USED TO INVEST IN THE ORGANIZATION OF COMPREHENSIVE RURAL HEALTH DELIVERY SYSTEMS TO SERVE MIGRANTS AND TO ATTRACT RESOURCES TO SERVE THE RURAL POOR.

- THE LEVEL OF FUNDING OF MIGRANT HEALTH PROJECTS BE ADEQUATE TO SERVE THE NEEDS AND ACHIEVE COMPREHENSIVENESS. SMALL PROJECT GRANTS SHOULD BE DISCONTINUED.

- DECISIONS TO FUND PROJECTS SHOULD BE BASED ON A DEMONSTRATION OF NEED.

- PROGRAM EMPHASIS SHOULD BE EXCLUSIVELY ON THOSE PROJECTS WHICH OFFER MINIMUM ADEQUATE COMPREHENSIVE PRIMARY CARE APPROPRIATE TO THE SETTING.

- PROJECT SPONSORS SHOULD BE SELECTED ON THEIR CAPACITY TO PROVIDE COMPREHENSIVE PRIMARY CARE, NECESSARY HOSPITAL AND SPECIALIST ACCESS AND CONSUMER PARTICIPATION.

- PROGRAM GUIDELINES FOR MIGRANT HEALTH PROJECTS MUST BE ISSUED IMMEDIATELY.

- ONLY PROJECTS WHICH INCLUDE CONSUMER INVOLVEMENT SHOULD BE SUPPORTED. MINIMUM STANDARDS FOR CONSUMER PARTICIPATION MUST BE INCLUDED IN THE NEW MIGRANT HEALTH GUIDELINES.
- MIGRANT HEALTH PROJECTS MUST BE ORGANIZED TO MAXIMIZE INCOME FROM OTHER SOURCES.
- PLANNING AND PROJECT DEVELOPMENT GRANTS OUGHT TO BE MADE TO POTENTIAL PROJECT SPONSORS IN PRIORITY MIGRANT SETTINGS.
- ADEQUATE TECHNICAL ASSISTANCE MUST BE PROVIDED TO MIGRANT HEALTH GRANTEES.
- THE ROLE OF THE STATE HEALTH AGENCIES SHOULD BE DRASTICALLY MODIFIED TO CONFORM TO THE NEW POLICIES OF COMPREHENSIVENESS AND CONSUMER INVOLVEMENT.

C. Administrative Recommendations

In addition to the administrative consequences of the recommended program strategy, several other administrative modifications should be made which will improve program operation:

- THE DEFINITION OF MIGRANT, FOR THE PURPOSES OF DETERMINING SERVICE ELIGIBILITY, SHOULD BE INCLUSIVE OF MIGRANTS (BOTH IN-MIGRANTS AND OUT-MIGRANTS), RECENT FORMER MIGRANTS, SEASONAL AGRICULTURAL WORKERS AND THEIR FAMILIES.

The program has never been clear about eligibility for services. The 1970 amendments clarify service eligibility by broadening the definition to include seasonal farm workers. The new eligibility criteria must be clearly defined in the new guidelines.

Currently, projects use a variety of eligibility definitions which sometimes even change during the program year or vary by different program components. Other projects invest grant funds in expensive procedures to establish program eligibility. Control of utilization should be in the selection of appropriate settings rather than in strict enforcement of invidious distinctions among types of indigents.

- PROJECT FUNDINGS SHOULD BE FOR THREE YEAR PERIODS, WITH ANNUAL REVIEWS, REPORTS, PLANS AND BUDGETS, BUT WITHOUT THE ANNUAL PROCESS OF APPLICATION REVIEW.

The strategy of concentrating program resources in the creation and organization of health delivery systems requires more security than that offered by the annual project grant process. A comprehensive project grant must be a commitment to at least three years project operation.

- LOCAL SHARE REQUIREMENTS SHOULD BE MODIFIED.

The Migrant Health Act allows for paying "part of the cost" of projects. This has been implemented as a requirement for local matching funds which has never been defined, audited or enforced. The current local share requirements fail to generate resources and only serve to make participation difficult for organizations composed of low-income consumers. The requirements must be modified to allow credit for volunteer services from non-professionals, space and equipment. There should be no minimum matching formula which would eliminate participation of consumer groups.

- HOSPITAL ACCESS SHOULD BE REQUIRED OF ALL PROJECTS AND HOSPITALIZATION SHOULD BE AN ALLOWABLE PROJECT EXPENSE.

Hospitalization is a necessary component of comprehensive health care and a basic stated need of migrant consumers. Access to hospitalization for acute conditions and maternity must be required of every project as a condition of funding. Migrant access to hospitalization should be incorporated into a written agreement which assures patient access, patient support, staff priviledges for project physicians, participation in utilization review and assurance that migrant patients will receive the same services as other patients.

Migrant funds should be used for hospitalization, but only as a last dollar resource.

D. Recommended Program Coordination

Project site visits demonstrated that the current Migrant Health Program is ineffective in diverting other health programs into serving migrants. Health department sponsors seldom redirected their existing categorical programs but often used part of their migrant grants for non-migrant purposes. The recommended program strategy (investment in a few large grants) is designed to maximize the capacity to generate outside resources and to create health delivery systems that will enable migrants to benefit from any of the alternative national health proposals.

Most of the potential "other resources" which exist are programs of DHEW. These can, through departmental and HSMHA leadership, be coordinated in support of the migrant health program. For example, Family Planning, Community Mental Health and Maternal and Child Health grants could be made to migrant grantees. This would both expand the scale of the migrant project and integrate preventive care into a comprehensive ambulatory care system.

The project visits also showed that migrants are generally neglected by HSMHA planning programs (RMP, CHP and HMO) either as participants in planning or as beneficiaries. DHEW hospital facilities and Medicaid programs fail to serve migrants. Migrants, although they are medically indigent, must go forty miles or more to hospitals that will accept them -- although facilities constructed with Hill-Burton assistance are often closer. Migrants, because they fail to show "intent to reside" and are not categorically eligible for welfare (as aged, blind, disabled or dependent child) seldom receive Medicaid benefits. Except for unemployed seasonal workers in California and hospitalized migrants in New York, Medicaid (Title XIX) is not an available health resource. Formula grant health programs (for example, Maternal and Child Health) seldom serve migrants even if the MCH funds go to the same local health department which sponsors the migrant health project. Even proposed national programs are unlikely to benefit seasonal and migrant workers because the casual nature of agricultural employment makes income documentation difficult and because seasonal workers are ineligible for FHIP.

DHEW can assist migrant projects by expanding the Emergency Health Personnel Act and allowing migrant projects to contract with PHS for physician services when adequate medical manpower is not otherwise available. DHEW can also integrate health services for the Migrant Education Program of the Office of Education by requiring the OE projects to spend 15% of their budgets for health services and to purchase such services from migrant health projects whenever there is one in the area. This recommendation could produce as much as $7.5 million in health services to migrant children.

The project evaluations demonstrate that major improvements can be made in the program simply through focusing existing federal health resources on the problems of migrants by investing other resources through the new delivery system recommended for migrants. Such an approach requires coordination of several divisions of HSMHA and leadership to ensure cooperation. It is important becuase it expands resources available to migrants, allows, several programs to share administrative costs and provides program access to previously unserved areas. To implement this approach, it is recommended that:

- DHEW MUST TAKE LEADERSHIP AND REQUIRE ITS CATEGORICAL HEALTH PROJECTS TO PROVIDE SERVICES TO MIGRANTS THROUGH THE COMPREHENSIVE DELIVERY SYSTEMS ORGANIZED WITH MHP GRANTS.
- DHEW MUST REQUIRE ITS HEALTH PLANNING AND DEMONSTRATION PROGRAMS TO INVOLVE MIGRANTS AND SERVICE MIGRANTS WHERE APPROPRIATE.
- DHEW MUST REQUIRE THAT SERVICE TO MIGRANTS BE A CONDITION OF APPROVAL OF STATE PLANS FOR HILL-BURTON FACILITIES, TITLE XIX AND STATE PLAN FORMULA GRANT PROGRAMS.

- DHEW MUST ASSURE COVERAGE OF SEASONALLY EMPLOYED MIGRANTS AMONG THE INDIGENTS ELIGIBLE FOR THE PROPOSED FAMILY HEALTH INSURANCE PLAN.
- DHEW SHOULD IMMEDIATELY SEEK ADEQUATE APPROPRIATION FOR THE EMERGENCY HEALTH PERSONNEL ACT OF 1970.
- DHEW SHOULD COORDINATE HEALTH SERVICES AVAILABLE THROUGH THE MIGRANT EDUCATION PROGRAM AND THE MIGRANT HEALTH PROGRAM.
- ADDITIONAL RESEARCH MUST BE CARRIED OUT ON THE EFFECTS OF AGRICULTURAL PESTICIDES, HERBICIDES AND OCCUPATIONAL INJURIES.
- MIGRANT HEALTH PROJECTS SHOULD BE LINKED TO AND SUPPORTIVE OF OTHER PROGRAMS SERVING MIGRANTS INCLUDING PARTICULARLY FOOD STAMPS AND LEGAL SERVICES.

E. Summary of Recommendations

The recommendations arising from the study of the Migrant Health Program are listed below. Recommendations which entail new or increased appropriation are shown under "costs." The action required shows the primary "actor" and the basic action necessary to carry out the recommendation. "Strategy recommendations" are those which are necessary to carry out the recommended strategy of concentrating program resources in fewer but larger grants in areas of greatest need using comprehensive program models and appropriate sponsors.

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION	COST	ACTION REQUIRED		STRATEGY
		ACTOR	ACTION	
1) increase appropriation	$10 million	cong.	appropriation	no
2) maintain program as categorical	none	none	none	yes
3) continue MH Program	none	none	none	yes
4) invest in system organization	none	MHP	grant + TA policy	yes
5) larger grants	none	MHP	"	yes
6) fund greatest need	none	MHP	"	yes
7) fund comprehensive projects	none	MHP	"	yes
8) issue guidelines	none	moot	--	yes
9) definition of migrant	none	MHP	grant policy	yes
10) consumer participation	none	MHP	"	yes
11) sponsor criteria	none	MHP	"	yes
12) modify state role	none	MHP	"	yes
13) provide technical assistance	none	MHP	"	yes
14) maximize 3rd party reimbursement	would generate $	MHP	grant + TA policy	yes
15) 3-year funding	none	MHP	"	no
16) planning grants	none	MHP	"	yes
17) modify local match	none	cong.	amend act	no
18) hospitalization	none	MHP	grant policy	yes
19) DHEW categorical programs	none	HSMHA	coordination	no
20) CHP, RMP, HMO etc.	none	"	"	no
21) Hill-Burton, Medicaid	none	"	"	no
22) migrants in FHIP	none	"	"	no
23) emergency health personnel	yes	cong.	appropriation	yes/no
24) migrant education	would generate $	DHEW	coordination	no
25) research	none	HSMHA	"	no
26) other program linkage	none	MHP	grant policy	no

Question

Please identify the overhead cost for each of the 103 projects in terms of dollars and the ratio of administrative personnel to clinical personnel.

Answer

Grantees are not required to submit line item budgets, therefore it is not possible to identify from our files administrative personnel and other overhead costs in contrast to service costs. However, in fiscal year 1973, 24 projects requested reimbursement for indirect costs under the DHEW policy which permits grantees to be fully reimbursed for indirect costs at a negotiated rate. The amount allowed for indirect costs in these projects was $366,941 out of a total of $4,452,270 awarded to these projects from 1973 funds.

The administrative costs in any project are considered part of the cost of providing services. If they are not provided through the grant, then they are indirectly provided from other funds available to the grantee agency.

Mr. FLOOD. Mr. Robinson.

NATIONAL HEALTH INSURANCE

Mr. ROBINSON. With regard to the neighborhood health centers and your remarks with reference to the extent of collections at the present time being 13 percent estimated to go to 20 percent, and you hope to be able to improve it beyond that point, what would be the effect of national health insurance with regard to that collection rate, based on your appraisal, or have you made such appraisal?

Mr. BUZZELL. It would go up substantially. It would probably permit the neighborhood health centers to become self-sufficient, but it would take some time from the passage of the act until such time as that occurred.

I think we are a number of years away from being able to say the centers are self-sufficient.

The answer to your question is that it would put it in the 70 to 80 to 90 percent range almost immediately.

INCREASED EFFECTIVENESS OF OPERATIONS

Mr. ROBINSON. Based on your justification, page 25, you estimate that because of increased effectiveness of operations in the center and collections of third-party funds, a 10-percent increase in the number of patients is projected for 1975.

How does the effectiveness of operation and collection affect the number of patients that you will be able to serve? Does this mean an increase in the staffing of the centers?

Mr. BUZZELL. Yes.

I want to make sure I am clear on this point for the record. The centers will utilize the additional funds collected. We may not in every instance put the money back into the same center, but it will stay in this category of health centers.

To the extent that the health centers collect more money, they will have more staff to provide more services.

Furthermore, as an incentive, we are going to encourage and will direct our efforts to providing that money back into the same center, assuming there is a need for increased services there. It is a very positive initiative.

FAMILY HEALTH CENTERS

Mr. ROBINSON. You mentioned in your discussion with the chairman that there are a number of family health centers that will in all probability convert to HMOs. Do you have any sort of listing, or is this just a ball park estimate?

Mr. BUZZELL. We estimate that two to three, a limited number, this next fiscal year will be involved in the HMO business.

Let me see if I can clarify the point, if I may.

The family health center, just like a group medical practice in the private sector, may well be in an HMO-type business for only a percentage of its activities. In other words, a percentage of the patients seen may be on a capitation or prepaid health coverage basis, and many of our group medical practices at the present time are involved in an HMO-like activity on that basis.

That is exactly what is happening in terms of some of our health networks and family health center projects. They continue to see patients who do not have a capitation type of coverage.

A good example would be a medicaid population. Ten percent of the patients seen by the family health center could well be entitled to medicaid. That center, we think, should be entitled to contract with the State medicaid agency for the coverage of those individuals.

That would be one good example of how you could get into this phenomenon of a family health center being in the HMO-type business.

I think I may have created some confusion by leaving the impression that the HMO program we are running will fund family health centers. What will fund family health centers are the 314(e) grants we make plus third-party insurance mechanisms like medicare and medicaid. They will be getting funds from a number of sources.

Mr. ROBINSON. Do you have any way to identify those that might be so handled at the moment and, as I indicated earlier, any estimate of the number involved?

Mr. BUZZELL. To the first part of your question in terms of identifying those, they will be, under the auspices of the HMO program, conducting a number of studies. I would want to do that with our other providers—our neighborhood health centers, family planning centers, family health centers, our health networks—in order to ascertain the degree to which they ought to be getting into that kind of business.

I think I ought to point out, also, that it is quite conceivable that one of these projects—in fact, we have in Rochester, N.Y., a network called the Rochester Health Network, which has already gone into the HMO business. They are doing it in terms of marketing their services not only to the medicaid population, but also to the private sector.

It is quite conceivable that somebody in the private sector covered by insurance through an employer would join one of these networks. We foster that development.

Mr. ROBINSON. But you do not have an estimate as to the number of these centers that might be involved in the next fiscal year?

Mr. BUZZELL. The best estimate we have, which is not that firm, is somewhere on the order of 10 to 15.

We are very much interested in working closely with the centers in order to identify all mechanisms available for reimbursement, (1) in anticipation of comprehensive health insurance, and (2) because the universal need is far greater than the amount of grant money we have.

An excellent way to supplement their total operating budget is to use the third-party mechanisms—private insurance or otherwise. It is working quite well.

One more thing. The 20 percent is the upper limit. That is why I am a little bit more confident on the potential in terms of family planning.

Mr. ROBINSON. From 13 to 20?

Mr. BUZZELL. From 13 to 20 percent in the neighborhood health center area.

As Dr. Shultz indicated, he hopes the family planning centers will be at the same level. It represents a major effort. These health services programs approximate $800 million. If 10 percent or more of their operating costs can be recovered, we have in effect an $80 million to $90 million increase in the budget.

Mr. Robinson. I certainly extend my best wishes in that regard.

Mr. Buzzell. One of the problems is taking it from one pocket and putting it in another. That is not always the case. When we improve reimbursements through medicaid and medicare programs, that money is also arrived at through tax revenues. Nevertheless, they are entitled to that coverage.

The States are participating. It is important to continue that effort, I believe.

MIGRANT HEALTH

Mr. Robinson. With regard to migrant health, which is of interest to me because of the migrant program in Virginia and the fact that I come from a community where we have a labor camp housing approximately 2,000 of these persons, and being familiar with the way that the health costs are financed in that particular camp through assessments against the grower-user to pay for Blue Cross-Blue Shield insurance on the workers in that camp, I wonder about your knowedge of the extent that this assessment against grower users, the development of a program whereby you do not have to involve taxpayer funds in order to take care of these people, is used in other areas as well.

Mr. Buzzell. Let me defer to Dr. Batalden, because I am not certain that my answer is correct.

Your question is in reference to the fact that the growers in Virginia are assessed in order to provide Blue Cross-Blue Shield coverage?

Mr. Robinson. They are in this particular camp. This is not a Virginia program. This is strictly local.

Mr. Buzzell. Who mandated that? The State?

Mr. Robinson. No, indeed. The association itself. It is strictly voluntary.

Mr. Buzzell. I see. I thought you were indicating somebody had mandated the grower to provide that coverage.

Mr. Robinson. No. I am just interested in whether or not you attempt to encourage this voluntary type of program or support the involvement of the Federal Government, and the States as well, in terms of requiring that they meet certain standards.

Mr. Buzzell. I support the notion, No. 1, that they be provided with coverage, and that the growers share in that cost and the Federal Government share in that cost. I believe, whether in Florida, Texas or Virginia, the medicaid program should be made as readily available to migrants as to other people.

I also believe that we have to provide a substantial amount of assistance to the growers in terms of patient care and sanitation projects, and things that need to be done. I think that is a joint endeavor of the State, the Federal Goverment, and the growers.

I do not think that the problem is readily addressable by simply saying to the grower that you need to provide a minimum of housing for migrants while they are at your place for 2 months of the year at a similar standard throughout the country. It is not feasible. By the same token, I think they do need to meet certain standards and that we have a responsibility to participate with the growers in terms of financing.

I think those standards ought to have some degree of flexibility across the country. One of our major problems is the disparity that exists between the quality of the camps in one section of the country and that of camps in another section of the country. In our high-impact areas we have some of our worst problems.

DECREASE IN MIGRANT POPULATION

Mr. **Robinson.** Does your program acknowledge the fact that the migrant labor stream is drying up, that there are decreases in the number of those involved as the years go on in terms of our domestic migrants?

Mr. **Buzzell.** If it does, it without information. The problem, in my judgment, is that we have not yet determined how many migrants we have in the country. I do not know that we can ascertain with certainty whether it is drying up or growing. We do not even agree on a definition of what a migrant is.

Mr. **Robinson.** If you will use information which is available at our State employment offices where the migrants are used and through which they are recruited, you could at least find out that they are drying up.

Mr. **Buzzell.** I have served with the Department of Labor for a period of time and am aware of the problem with the Department of Labor's definition of migrant. In health services we too have some problems, I think, in using a fixed definition of who is a migrant.

As you know, in the Labor Department they get into local farmworkers versus migrant. They are potentially all the same. They need health care. At the present time, in my judgment, they are not receiving adequate attention.

Mr. **Robinson.** I do not mean to indicate that the problem still does not exist, and it must be solved. But I do think it must be taken into consideration that all statistical evidence, to the best of my knowledge, based on the agricultural user of this type of labor, indicates that there are fewer and fewer that migrate each year.

Mr. **Buzzell.** I guess one of my concerns is that, even so, the number is so great as contrasted with what we are doing, it is a problem that will be with us for some time.

Mr. **Robinson.** This is the statement I expected you to make, and I acknowledge it.

Dr. **Batalden.** That is the point I was going to make. I think the changing locations of the projects we support reflect that when a given area no longer attracts a large number of migrant workers, that project is not continued in the sense that we do not continue to feed that project with Federal support but, rather, deploy those funds in other areas that are still underserved.

INPATIENT SERVICES FOR MIGRANTS

Mr. **Robinson.** You mentioned that you support six migrant projects that will enable 50,000 migrants to get inpatient services. I would like to know where those six projects are and how much they cost.

Mr. **Buzzell.** That is correct, we are supporting six projects.

As you know, one of our major problems is providing hospitalization care for migrants. The six projects, depending on your perception, unfortunately are not in Virginia. Two are in Florida.

The conditions of the health care in Virginia, in migrant coverage, happens to be better than in these other places. I am not so sure it is necessarily a desirable thing, in fact, to have this demonstration program located in your particular district.

Mr. ROBINSON. I am glad to hear you say that, because I helped draft the legislation that is responsible for that condition in Virginia.

Mr. BUZZELL. I want to acknowledge that, because it is a fact that that was one criteria.

At the time we launched the program, it was not the migrant season in Virginia.

I would point out that we are quite enthusiastic about the early returns from this program. As you know, this is in effect an interagency working relationship with the Bureau of Health Insurance. We believe there is some potential to take this demonstration project and do something a little bigger with it. It is a very, very futile experience to go back and identify a migrant health center that needs hospitalization coverage and not have the wherewithal to provide it.

We have that problem in our Indian Health Service, a backlog of health care needs.

I am sure if we were able we could identify the same kind of serious health care crisis in the migrant and local farmworker population.

Mr. ROBINSON. For the record, will you identify the six projects and the cost of them?

Dr. BATALDEN. We will be happy to provide that for the record.

[CLERK'S NOTE: The information appears on page 646.]

Mr. ROBINSON. Thank you, Mr. Chairman.

REORGANIZATION

Mr. OBEY. Just a few questions.

First of all, I notice in yesterday's Federal Register publication of the reorganization of the Health Services Administration.

It is not slow work, your being here 1 day after the reorganization is published in the Federal Register.

Mr. BUZZELL. We have been at that for a year.

MATERNAL AND CHILD HEALTH

Mr. OBEY. I was looking for maternal and child health care, and I found it seemingly buried. What is it doing there? Isn't that really a downgrading of the program?

Mr. BUZZELL. Maternal and child health is located in the Bureau of Community Health Services, as is the HMO program—you heard me testify a month ago as to the importance of the HMO program—as is the National Health Service Corps.

Mr. OBEY. Did it not used to be separate?

Mr. BUZZELL. When I arrived and became the administrator of so-called HSMHA nearly a year ago, maternal and child health along with roughly 35 other major areas of responsibility reported directly to the administrator, for all intents and purposes. It was one of many categorical programs—by the way, including NIOSH.

I think that there was a misunderstanding that, by having alined the organization in a categorical arrangement along with 35 other programs, access to the administrator and then to the Assistant Secretary for Health was at a higher level and thus one was able to do more for a constituency.

The fact of the matter is that this is incorrect.

Mr. OBEY. I think you are probably correct. I wanted you to state it for the record, because I have had some questions on it.

There was a lot of hell raised, for instance, because the first draft of the committee reorganization proposed abolishing the Merchant Marine and Fisheries Committee. As a matter of fact, my guess is that if those groups had a broader constituency within a larger committee, they might in fact do better legislatively in the long run.

Mr. BUZZELL. I would like to make one more point, if I may, with your permission.

That is, we did not necessarily do a disservice to our people by this reorganization. We were asking our people to be financial managers, clinicians or people capable of monitoring clinical services. The way we were structured, a particular program in maternal and child health had to have the full spectrum of experts or technicians across all lines. They had to have physicians to insure quality care.

Mr. OBEY. Last year Congress restored 58 positions for maternal and child health care that the President's budget suggested be deleted. Were those positions filled in 1974 or not?

Mr. BUZZELL. Those positions were never vacated in 1974. To make sure that I am not facetious, those positions are scheduled for termination in June of this year. To clarify the record, they were not vacated last year.

MATERNAL AND CHILD HEALTH FORMULA GRANTS

Mr. OBEY. How much are you requesting for formula grants to States for maternal and child health care services?

Mr. BUZZELL. $243,951,000. In fact, we are requesting that all the service money be on a formula grant basis.

Mr. OBEY. Correct me if I am wrong on this. Could it not be said that you are in effect taking about $18 million away from formula grant funds in section 503, I believe it is, that would have gone to States like Iowa, Kentucky, Wisconsin, New Jersey, and Virginia, and switching it to section 516?

Mr. BUZZELL. Let me answer the question, and correct me if I am wrong, Paul.

Dr. BATALDEN. Mr. Obey is correct.

Mr. BUZZELL. The answer is "Yes." I would like an opportunity this afternoon——

Mr. OBEY. It will be switched, I understand, to project grants to States with more urban population and major maternal and child health care commitments.

Mr. BUZZELL. I would like to have the opportunity in the afternoon to provide you a thorough answer to that question or answer it for the record, because it is a complex problem. Essentially, you are correct.

Mr. OBEY. Expand on it for the record.

[CLERK'S NOTE. The information appears on page 643 of this volume.]

Mr. OBEY. Let me make this point. I thought last year when we enacted section 516 project grants, it was not to be at the expense of formula grants. It was my impression that all States had statutory obligations to get projects underway for maternal and infant care, children and youth, dental care for kids, and newborn intensive care.

My question is: How can they get those underway with less formula money than heretofore?

Mr. BUZZELL. Let me illustrate by using your State. Wisconsin in 1974 received $2.7 million for maternal and child health. Wisconsin in 1975 will receive $4.4 million, in spite of our problem in terms of carrying out the full intent of the legislation, because, as you may recall, it was also the intent of Congress that we continue the major urban-type projects.

In spite of the problem, in this instance we are going to provide Wisconsin with the wherewithal to complete the program.

Mr. OBEY. I would like to discuss this more with you, but I do not have time. I do want to make this quorum call.

Mr. BUZZELL. You will acknowledge that is a substantial increase.

Mr. OBEY. Yes.

Mr. BUZZELL. I have some problems with other States. This does not happen to be one of them.

Mr. OBEY. Thank you very much.

We will reconvene at 2 o'clock.

MIGRANT INPATIENT CARE

Mr. FLOOD. The committee will come to order.

When we recessed with my questioning we were talking about migrants and migrant health.

In fiscal year 1974 you initiated a demonstration project whereby the Bureau of Health Insurance of the Social Security Administration acts as a fiscal intermediary for you people and for reimbursing hospitals where you provide for migrants. What kind of experience have you had to date? Have you had any major problems?

Mr. BUZZELL. Mr. Chairman, just before we recessed at lunch we got into this topic, and we didn't complete it so I am glad you brought it up.

We are not encountering any major difficulties. We have just started though. We think that it is going to be of major benefit to the migrants because, as you know, they traditionally have a very difficult time getting hospitalization coverage. The Bureau of Health Insurance, SSA in Baltimore is working closely with us, and that itself is a breakthrough.

Mr. FLOOD. What do you mean by SSA?

Mr. BUZZELL. It is the Bureau of Health Insurance within the Social Security Administration, a sister agency in HEW.

Mr. FLOOD. There is no major problem. Of course you are going to have problems with hospitalization of migrant workers naturally, but we are concerned about any major problems.

Mr. BUZZELL. No major problems. The only problem is the problem that Mr. Robinson alluded to, and that is that a demonstration project only covers a certain number of people in a few States.

Mr. FLOOD. How do you reimburse the SSA for this service?

Mr. BUZZELL. We sign an agreement with SSA. The money is provided from the project grant requests, and we pay them directly.

SANITARY CONDITIONS OF MIGRANT CAMPS

Mr. **Flood**. We have had all kinds of stories down through the years about the sanitary conditions in migrant camps. Some of the ones I have seen, my. But this is some time ago. In 1974 you conducted a survey of approximately 29 migrant camps to determine the sanitary conditions in those camps. Can you tell us what the findings of those surveys were?

Mr. **Buzzell**. Yes, they are findings that we are not especially proud of.

For the record I ought to indicate we selected 29 of the camps on a random basis, and from that sample 13 percent were dumping sewage directly into the open streams; 26 percent of the toilet facilities were rated as being dirty and foul smelling; 35 percent did not have toilet paper; 22 percent were not taking water samples. Thus, there is no assurance of their water safety.

These are just indicative of the kinds of problems.

Sanitary conditions in the migrant camps vary significantly and in many of the camps they do not meet anybody's standards.

Mr. **Flood**. What are you doing to improve the situation?

Mr. **Buzzell**. We are attempting to work closely with the States. The responsibility basically is with the States. We are working closely with them to encourage and assist the States in enforcing proper sanitation practices. We are not financially funding these efforts directly in the migrant health programs.

Mr. **Flood**. We would like to be kept pretty well informed about this from time to time if you find any major problems. You have geographic problems and nationwide problems. We realize you are up against the north, east, south, west business. We would like you to, instead of once a year having you dust off this thing, keep the staff of this committee informed on a continuing basis.

Mr. **Buzzell**. We will be glad to.

I would like to also point out you will have the opportunity later today or tomorrow to talk with Dr. Sencer from the Center for Disease Control and they also are involved in this problem.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. **Flood**. But you are the top guy and we want it from your shop.

On the Health Maintenance Organizations—that permits me now to say HMO's—can you tell us your priorities for spending the funds you have asked for in this budget?

Mr. **Buzzell**. Our priorities?

Mr. **Flood**. Yes.

Mr. **Buzzell**. Yes. You know we asked for a supplemental request about a month ago, and we asked for "until expended" authority. We hope this calendar year that we are in would be the year in which we spend that supplemental, and that is the $65 million.

In terms of priority—and again I would like to mention that before lunch the question was asked—do we have a plan whereby we shall know what each State is going to receive? The answer to that was we do not. It is not a State-by-State or a formula program. So in terms of priorities, in terms of States, or in terms of grantees, we don't have any. It is open season really.

We are going to, as a priority, fund feasibility studies, planning studies, and developmental studies with direct grants.

The priority is going to be on those organizations which are nonprofit organizations. In fact that is the only kind of an organization that will get the direct grant money.

The priority also will be placed on those organizations that truly are interested in the development of HMO's. In some instances, as the law specifies, it has to be their principal activity.

So to answer your question a slightly different way, a major well-qualified group medical practice that wants to get into the HMO business has to do that from the viewpoint of its being a major activity of the group.

Mr. FLOOD. Let me ask the question in a slightly different way. Why do you believe that this set of priorities you are telling us about will contribute to all of the goals of the legislation?

Mr. BUZZELL. Starting an HMO and having it be successful, like the one you are familiar with in Pennsylvania, is a business. It is different from running an ambulatory care center with grants. They have to be self-sufficient. We help them for 3 years. Once they go operational, then we will cover their cost deficits for 3 years or assist them in getting their losses covered. But they eventually, as the one you are familiar with does, have to stand on their own two feet. They have to market their services; they have got to convince people to join the HMO. So we have to place a very strong priority, in my judgment, on the economic viability; good business management, marketing, and high quality of medical services. The law requires that we provide quality service. They have got to have providers. Just as the PSRO program to work has to have the doctors supportive of it, the HMO program faces the same problems. So we are placing a high degree of priority on HMO's being high-quality medical organizations which also can take care of the business and the marketing factors.

CIVIL SUITS

Mr. FLOOD. Here is something. You say in the budget justification that civil suits may be brought against the organization which fails to comply with section 1310.

Mr. BUZZELL. Yes.

Mr. FLOOD. Who decides whether or not to undertake such a civil suit?

Mr. BUZZELL. Technically the Secretary of HEW will make that decision.

We have to provide regulations which will dictate how that comes about, but the law does, as you indicate, provide sanctions in which civil suits can be brought.

Before we do that we will be certifying and regulating HMO's; then, subsequently, HEW will be in the business of applying civil sanctions if necessary.

HMO BREAKEVEN POINT

Mr. FLOOD. You mentioned this a minute ago. When you testified before us on the supplemental appropriation you told us to be justifiably economically sound and viable the HMO needed 1,000 enrollees, a round fat number. Something funny must have happened on the way to the forum. You are back now with this 1975 budget and tell us an HMO will need 20,000 or 30,000 enrollees just to break even. In this numbers game which is correct?

Mr. **Buzzell**. I am pleased to have the opportunity to clarify that.

Mr. **Flood**. That is good.

Mr. **Buzzell**. Apparently we left a misimpression.

Let me answer this way: It is conceivable, not only conceivable but quite possible, that an HMO can lose money regardless of how many enrollees it has.

On the other hand, an HMO with a relatively small number of enrollees, like Geisinger Clinic in Pennsylvania which doesn't have too many enrollees—I think in the order of 1,000—that HMO is successful. It is making money.

There are others that will never make money unless they improve their business management practices.

The 25,000 versus 1,000 relates to the two different kinds of HMO's we talked about. The so-called foundation model where you don't build the building and don't take the physicians and put them together in a single place, but you let them continue to practice in the settings they are in now is a less costly model in the sense of not needing major capital to become operational. It is therefore quite possible under that kind of arrangement, which is not dissimilar to the group medical practice, for that kind of HMO to make money, be successful, have a good premium structure with only 500 or 1,000 enrollees.

On the other hand, if you are going into the big business of having your own hopsital, having your own clinic, having a large number of physicians on salary and a major marketing program where you are going to try to sign up a lot of people, then it will take a large number of enrollees, maybe 25,000 or 30,000, before you can reach break even, Mr. Chairman.

Mr. **Flood**. Talking in months, how long do you estimate it will take an HMO to go from zero enrollees up to 20,000 or 30,000 which you say is required to break even?

Mr. **Buzzell**. Some of them have been trying to do it for many years.

Mr. **Flood**. That isn't what I asked you.

Mr. **Buzzell**. It is quite conceivable in the next 2 or 3 years some group will start an HMO in which they will have 25,000 enrollees in the very first month or they will have 25,000 enrollees in the very first 6 months. I can illustrate that with an example.

We have potential HMO's out there which are being supported by major employers like Weyerhauser, the large lumber company in the Northwest. If that kind of an organization sponsors an HMO along with the doctors and with the other people, they may start right off with a major enrollment of 10,000 or 15,000.

HMO DEFICITS

Mr. **Flood**. How will the other kind of HMO cover deficits beyond the 36 months of deficit support provided by the law? The HMO will not go under after 36 months support will it?

Mr. **Buzzell**. I would say generally not, or if it did, we would have made a mistake in terms of supporting them.

They will be getting loans. We provide loan guarantees and they borrow from a bank and receive backing that way. There is a good likelihood they will have a line of credit well beyond the 3 years.

Mr. **Flood**. Your justification points out that section 1308 authorizes the Secretary to borrow from the Treasury the dollars for a loan guarantee if the institution goes into default. What rate of default are your projecting?

Mr. **Buzzell**. As I recall when we testified the last time we said if more than 25 percent of all of the grantees we provide planning and development money to defaulted we will have not done our job. Once they become operational, it would be my judgment that something in the order of 95 percent or more should continue on to a long economically viable life. I don't believe once they get into the 3-year operational period that the potential for failure is any higher than 2 or 3 out of 100. If that happens, we have done a great disservice to a lot of people.

TECHNICAL ASSISTANCE

Mr. **Flood**. In the matter of program management, what we call direct operation support, how much money are you requesting for technical assistance for the grantee organizations?

Mr. **Buzzell**. Approximately $4 million.

Mr. **Flood**. Why don't you put the money directly in the grant award and let the grantee purchase the kind of technical assistance he thinks he needs? This is the big brother business again. What is the matter with that?

Mr. **Buzzell**. I think that is a good suggestion.

NEW POSITIONS

Mr. **Flood**. What do you want with 25 new jobs? Only a couple of weeks ago in the request for the supplement you had 100 new jobs for staff positions. Did you drop that on the floor?

Mr. **Buzzell**. We left a few behind.

Mr. **Flood**. That is what I thought.

Mr. **Buzzell**. The second stage of the implementation of the program starts in July when we start performing HMO certification and regulation. We have a major certification and continuing regulation responsibility that starts approximately in July or August, and that will require additional staff.

Mr. **Flood**. How many of those are going in the regional offices?

Mr. **Buzzell**. We are projecting that somewhere—of the additional 25?

Mr. **Flood**. Yes.

Mr. **Buzzell**. As you recall in the supplemental we asked for 100 positions, and if that is approved then in the 1975 budget request there would be an additional 25 positions. Of the original 100, there would be 50 in the national office and 50 in the regional offices. Of the additional 25, in all likelihood 15 would go to the regions and 10 in the national office.

NATIONAL HEALTH SERVICE CORPS

Mr. **Flood**. Let's talk about the National Health Service Corps. Can you explain to us why there was a reduction of $594,000 in that program?

Mr. **Buzzell**. Yes. In the 1974 appropriation we received an increase of $2 million which did not become a part of our base for the 1975 request. Therefore, it appears that in the 1975 request there is a reduction. However, in terms of positions and direct services we have, in fact, a small increase.

Mr. FLOOD. How many vacancies do you have in that program at this time?

Mr. BUZZELL. This is an interesting program and we have had some interesting developments. By the end of June, in spite of the fact we lost the incentives of the physician draft and in spite of the fact that the uniformed services bonus bill hasn't been enacted, we will have a full quota of physicians. We will have all of these positions filled.

We at the present time have a shortage of physicians in the National Health Service Corps but that shortage runs in the order of 35 or 40, and that is in contrast to a situation last October where we were substantially behind. As a consequence, our 1975 budget request to the Office of Management and Budget was not totally supportable due to the fact that the 1974 budget provided for positions which could not be filled. We were having a difficult time recruiting physicians.

Mr. FLOOD. Your budget justification says your retention rate will be 25 percent in 1974. Do you have any ideas how you can improve that? Do you want to settle for 50 percent?

Mr. BUZZELL. We will be able to retain at least 50 percent of these physicians if the Congress will enact the bonus bill currently under consideration. The Senate has already passed that bill and the House is going to be considering that shortly. With the passage of the bonus bill we will be able to retain 50 percent or more of our physicians.

Mr. FLOOD. Of the 307 approved sites, as you state in your justifications, 275 will be staffed in 1975. When do you think you will be able to meet the requirement for staffing the 307 sites?

Mr. BUZZELL. Before the end of the new fiscal year. Dr. Batalden is anxious to point out not only will we do the 307 but we are going to qualify some more.

NURSING HOMES

Mr. FLOOD. Another bureau you have down there is the Bureau of Quality Assurance. What about nursing homes? Last year we were told that all State surveyors would be trained by the end of fiscal year 1974. What is the status at the present time of that program? That is an imporant program.

Dr. ABDELLAH. It is a pleasure to have an opportunity to speak to this very vital area.

Mr. FLOOD. You are the one that can do it.

Dr. ABDELLAH. I am Director of the Office of Nursing Home Affairs.

In terms of this surveyor training for last year the total trained would be 1,648, and 600 of these were State fire safety surveyors. We do estimate for 1974 we need to train an additional 350 surveyors.

Mr. FLOOD. How are you doing that?

Dr. ABDELLAH. This is a cooperative program with the Federal Government and States working together. There are also universities involved in the training programs, and Tulane is one of the major centers with a network program.

Mr. FLOOD. What do you think about it?

Dr. ABDELLAH. I think it is a very vital program particularly with our new regulations which were published last January and become effective this month. Without a good surveyor program, enforcement of those regulations would become very difficult. So we feel this is very critical.

One of our worries in this, and our Department will be submitting amendments a little bit later for the surveyor training, is that 100-percent funding for the medicaid surveyor training terminates June 30; we will be proposing that this be extended. We feel this is very important in order to continue the support for surveyor trainers who would be working particularly with intermediate care facilities which is an entirely new program.

OMBUDSMAN PROGRAM

Mr. FLOOD. Here is something you talked about last year. You told us you were initiating a new ombudsman program. How is that working out? Tell us first how it is working out and then how much you have in the budget for us.

Dr. ABDELLAH. Although our office does have responsibility for continuity of this program, technically it has been transferred to the Administraton on Aging under Commissioner Arthur Flemming. But we are working with Dr. Flemming very closely in relation to this program.

Actually there are now seven of these projects, and some of them have had more publicity than others.

We do feel that as a concept it is a very important program. It does need testing and evaluation, and this is critical. This is what we are endeavoring now to work out with Dr. Flemming to build in a continuity and evaluation. It does provide a very important mechanism for the consumer as a source of communication, to let us know what the problems are in the nursing homes.

RENAL DISEASE PROGRAM

Mr. FLOOD. We are going to be breathing down your neck on this one.

On the renal disease program, can you tell us where you stand on the end stage kidney disease program?

Mr. BUZZELL. May I use the opportunity to introduce two or three people whom you did not meet this morning? First of all we do have the second team here from the Comptroller's Office, Mr. Forbush. As you recall, Charlie Miller was here this morning.

Bob van Hoek is Associate Administrator and the man to answer your question is right behind me, Dr. Goran who heads the Bureau of Quality Assurance.

Dr. GORAN. In the renal program we now have about 14,000 beneficiaries who are eligible and receiving dialysis benefits under the program.

As you know we are still operating under interim regulations. We will in the very near future, hopefully in the next month or two, be issuing final policies for the——

Mr. FLOOD. The end stage renal disease program?

Dr. GORAN. Final regulations for the end stage renal disease program.

We expect over the next several years to continue the identification of the eligible beneficiaries, reaching an estimated 40,000 to 50,000 within the next 3 to 4 years. At that point it is estimated that the number of individuals who are receiving benefits will reach what is called the steady state.

Mr. FLOOD. I certainly hope you get your hope.

SOCIAL SECURITY PROVISIONS

Mr. PATTEN. Mr. Chairman, I would like to ask what effect the social security provisions have on your work?

Dr. GORAN. As you know the legislation authorizing the end stage renal disease program is an amendment to the Social Security Act, and the program itself is being jointly administered by the Office of the Assistant Secretary of Health, the Bureau of Quality Assurance in the Health Services Administration and the Bureau of Health Insurance in Social Security Administration. Simply stated, we are responsible for the medical aspects of the program and the Bureau of Health Insurance for the administrative/financial aspects of the program, the reimbursement process itself.

PROFESSIONAL STANDARD REVIEW ORGANIZATION

Mr. FLOOD. On the Professional Standard Review Organizations again, in your general statement you said that the Bureau of Quality Assurance has operational responsibility in the implementation of the PSRO program. What do you mean by that?

Mr. BUZZELL. Dr. Goran who heads that Bureau of Quality Assurance is responsible for all of our quality assurance programs, the biggest of which at the present time is the Professional Standard Review Organization program. So he has responsibilities for the implementation, the start up of the local Professional Standard Review Organizations and the Statewide resource centers and the entire implementation of that program. It is under his auspices with policy guidance from the Assistant Secretary for Health.

Mr. FLOOD. I thought so.

Mr. BUZZELL. Could I add one point on the renal matter. I have been fortunate in the last 2 months to visit two of our Public Health Service hospitals which are operating major kidney disease treatment programs, one in San Francisco and the other at Staten Island.

One of the things we want Dr. Goran to do in preparing those regulations is to spend some time at these two facilities because that gives us an excellent opportunity to in fact determine precisely what some of those standards ought to be. I am very encouraged with the work they are doing at those two hospitals.

PUBLIC HEALTH SERVICE HOSPITALS

Mr. FLOOD. On the Public Health Service hospitals, you say in your justification "A task force to study the future of the Public Health Service hospitals." How will the efforts of this task force differ from the efforts of the other task forces that made studies of the Public Health Service hospitals?

Mr. BUZZELL. Its mission at this time is not to look at the hospitals to ascertain how we can quickly close them. Its mission is to look at these hospitals, because we now have a mandate from the Congress, to ascertain what they ought to be doing, if anything, besides providing care to primary beneficiaries, basically Coast Guard personnel and the merchant seamen. We are looking at alternative medical programs such as kidney disease treatment.

In addition, we have a major program this year to provide repairs and improvements in these facilities. This task force, by the way, is under the direction of Dr. van Hoek. He is looking at each hospital to see what needs to be done in terms of improving it, repairs it needs, and other items.

COMMUNITY USE OF PHS HOSPITALS

Mr. **Flood.** It has been stated that one of the options in this whole matter you are considering is the transfer of PHS hospitals to community use. How many of the communities in which any of these hospitals are located have expressed any interest in taking over the hospitals and what is the quid pro quo on a deal like that?

Mr. **Buzzell.** This past year, we talked with many people in all of these communities. And the question generally was, Could we contract with this community for the care of these primary beneficiaries? And the answer was yes in most cases, and the cost would be so much per patient.

Some communities, like New York where we have the Staten Island Hospital, already have a shortage of beds.

Mr. **Flood.** How many communities have expressed an interest in taking over these hospitals?

Mr. **Buzzell.** They all have, but the quid pro quo, as you indicate, is the problem, one of economics. They are all interested in our willingness to pay the price.

The problem is that the Federal commitment has never provided enough money to pay the price in terms of amount of care to be provided.

But the answer is, with the exception of New York and one or two others, there is a willingness on the part of the community to take the patients whom the hospitals serve.

Mr. **Flood.** This is the Appropriations Committee as you know. Just like the Marine Corps, we have learned here we never volunteer. The reason no action was taken was nobody asked. You know that.

Have you put a pricetag on the demands of the communities, on anything in the various communities?

Mr. **Buzzell.** In terms of what they would charge to serve the people?

Mr. **Flood.** Yes.

Mr. **Buzzell.** They indicated to us what they wanted on a cost per patient day. In terms of the future and Dr. van Hoek's task force, we have not done that.

Mr. **Flood.** You can do this for the record. We would like the total dollars, patient load, and staffing allocated to each one of the hospitals.

Mr. **Buzzell.** We can provide that.

Mr. **Flood.** But for 1973, 1974, and 1975?

Mr. **Buzzell.** Yes, sir.

[The information follows:]

BEST COPY AVAILABLE

Hospitals	Positions				Budget (in thousands)			Average Daily Patient Load (ADP)		
	1973 Budgeted	1973 On-Board 6/30/73	1974 Budgeted	1975 Budgeted	1973 Budgeted	1974 Budgeted	1975 Budgeted	1973 Budgeted	1974 Budgeted	1975 1/ Budgeted
Baltimore	636	501	530	456	$11,147	$11,539	$11,373	149	117	112
Boston	289	268	269	269	4,217	4,454	4,568	72	48	77
Galveston	267	230	248	260	3,947	4,302	4,486	99	86	112
New Orleans	615	599	573	600	9,803	10,290	10,725	274	232	273
Norfolk	330	306	260	275	5,161	5,345	5,574	110	64	84
San Francisco	677	655	660	660	11,444	12,549	12,870	217	215	229
Seattle	509	475	480	500	8,980	9,260	9,622	136	123	174
Staten Island	1,042	1,002	1,041	1,041	16,437	18,136	18,601	343	385	400
Sub-total, General Hospitals	4,365	4,036	4,061	4,061	71,136	75,875	77,819	1,400	1,270	1,461
Carville	306	305	306	306	5,750	6,216	6,375	255	250	250
Total, All Hospitals	4,671	4,341	4,367	4,367	$76,886	$82,091	$84,194	1,655	1,520	1,711

1/ Revised estimate since submission of Congressional Budget

PROGRAM MANAGEMENT

Mr. FLOOD. On program management, you are talking about $35,783,000 and 903 jobs. How many of these positions are actually in the program management activity to administer the research—the training projects of the maternal and child health program?

Mr. BUZZELL. The program management budget includes 102 positions for the maternal and child health activities.

EMERGENCY MEDICAL SERVICES

Mr. FLOOD. On page 59 of your justifications, you state that you are responsible for "staffing, development of regulations, and the funding of projects for emergency medical service systems."

Why are you requesting positions for support of this program when the very same thing appears in the budget for the Health Resources Administration? Are you double in brass or what?

Mr. BUZZELL. No. We have recommended to the Secretary, and he has agreed, that the emergency medical services responsibility be transferred from the Health Resources Administration to my agency. So as a consequence, this program will not be in the HRA budget as soon as we can effect that transfer, that request for positions and dollars. We are only going to ask for it once.

Mr. FLOOD. That is nice. You are only going to get it once, and I am not sure you are going to get it.

PROJECT CONTRACTS

On contractual services, in your budget you are requesting $12,231,000 for what you call project contracts. Again, you can put this in the record. Give us a breakout there of the amount for each program with a brief description of the type of work being supported.

Mr. BUZZELL. I welcome the opportunity to put it in the record.

[The information follows:]

Project Contracts

Community Health Services - Activities will emphasize project management improvements, statistical reporting, project evaluation, policy guidance, professional advice and technical assistance to comprehensive health center projects. $687,000 is included for contracting with the California Rural Indian Health Board for health services for California Indians.	$3,722,000
Maternal and Child Health - Contracts with two universities and one private organization which provide direct services to Indian people.	750,000
Family Planning	
Training - Promotes the skills and knowledge of family planning personnel to provide effective voluntary family planning services	$1,000,000
Education - Gives direct support to service projects in the development of patient-oriented information and education programs	600,000
Services delivery improvement - Provides for special studies and programs to mount a coordinated program responsive to family planning priorities	2,515,000
Health Maintenance Organizations - Technical assistance contracts to facilitate project development in critical areas of their operations; that is, medical records, actuarial projections, information systems, financial planning and marketing strategy.	$2,000,000
National Health Service Corps - Technical assistance will be made available to develop viable health care systems, develop program information to publicize the Corps, recruit health professionals and to provide training.	964,000
Quality Assurance - Provides for contracts in such areas as: (1) alternative methods for quality standards and certification; (2) training of State agency survey personnel at all levels; (3) national registry of patients for end-stage renal dialysis program; (4) renal-organ procurement; and (5) development and administration of proficiency examinations for qualification under Medicare.	680,000
Total	$12,231,000

APPROPRIATION LANGUAGE

Mr. **Flood**. The next question is more general on new appropriation language. Up here language in an appropriation bill is our pet hate.

You are asking new language in this appropriation bill to "make payments for the costs of medical care and related expenses on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Ala." Why is that language necessary?

Mr. **Buzzell**. We need it to provide funds to provide for the care of these people. Dr. Sencer, who will be administering that program, is here. Any questions you have he can answer.

Mr. **Flood**. This is just for the purpose of the language only right now and not the merits. How many people are involved?

Dr. **Sencer**. There are 107 participants in the study who are still surviving. There will be a still to be determined number of spouses and children.

Mr. **Flood**. How did you arrive at that figure—you knew I would ask you that—of $1,600,000?

Dr. **Sencer**. This is an estimate that is based upon medicare actuarial figures. It came with a low estimate and high estimate based on per capita use of medicare and an upper limit based on maximum utilization. I can supply a detailed breakdown for the record if you would like. I have it right here.

[The information follows:]

Basis for $1,600,000 Cost Estimate, Tuskegee Stuty

Given the paucity of data for the target beneficiaries, estimates of the life expectancy and the cost of medical care must be of limited precision. National estimates of life expectancy and cost of medical care were used as a proxy for the target group, given the fact that participants lived in 14 different States.

The provision of comprehensive medical care for these special beneficiaries is estimated to be $1.6 million for this fiscal year. The medical care will be necessary over a projected 38-year period. It is difficult to project the total cost of medical care over this period of time and even more so on a fiscal year basis. These costs are based on personal health care expenditure per person served under an insurance situation. The gross expenditures have been adjusted downward to take into account medical care expenditures covered under the medicare program. Estimates for medical care transportation, burial, and administrative costs were added to the net medical care costs to arrive at the budget figure.

EMERGENCY MEDICAL SYSTEMS

Mr. **Flood**. On the emergency medical system, why is there a reduction of $8 million in the Emergency Medical System program? Have you lost interest in this program already?

Mr. **Buzzell**. Quite to the contrary. Before the Congress passed legislation on November 16, 1973, the program was just a demonstration program with nine demonstrations projects. Now with the enactment of the legislation, and with the supplemental budget request passed in January 1974, we are able to launch this program which is a matching program with the States. And we will be supporting feasibility, planning, and development efforts.

Mr. **Flood**. You stated in your justifications that the Federal Government will provide 50 percent of the costof establishing these emergency medical systems. But you also state that the Federal share may go as high as 75 percent if the recipients can demonstrate an exceptional need for financial assistance. What do you mean by that one? What is your yardstick?

Mr. BUZZELL. The Congress recognized that in some States—some areas—the Secretary ought to have authority to waive a portion of the matching requirement, and if there is a demonstrated need, it is conceivable——

Mr. FLOOD. Exceptional need?

Mr. BUZZELL. Exceptional need. It is conceivable an area could get a bigger percentage.

Mr. FLOOD. This is a matter of degree. They also all have to demonstrate a need. This is an exceptional need?

Mr. BUZZELL. That is correct. And we have the responsibility to define those exceptions. But those will be exceptions.

EMERGENCY MEDICAL SYSTEM DEMONSTRATION PROJECTS

Mr. FLOOD. You don't ask for any funds in the budget for continued support of the seven emergency medical systems, the demonstration projects, in 1974. Are you abandoning these projects or what happened? Did they quit?

Mr. RUSSELL. No. The States in which these projects are located will be looking at the emergency medical services subject from a Statewide viewpoint in many instances. The law is quite explicit in terms of requiring that a system be put out there with all of the pieces. And, as a consequence, the demonstration projects will now be folded into the entire program. They will get further assistance if, in fact, they qualify.

A good example would be the project we have in Illinois. They quite likely will qualify for further assistance but the State of Illinois will now have to contribute, or the localities—Springfield and these places—will have to contribute cash.

Mr. FLOOD. Peoria, too?

Mr. BUZZELL. That is a tough one.

MATERNAL AND CHILD HEALTH

Mr. FLOOD. On the maternal and child health grants, in fiscal year 1975, the project grants for maternal and child health will be discontinued.

Mr. BUZZELL. Yes, sir.

Mr. FLOOD. And all of the money will go to the States on the formula grant system.

Will any State receive a lesser amount in 1975 than it received in 1974?

Mr. BUZZELL. Yes.

Mr. FLOOD. Give us a list of the States and the amounts.

Mr. BUZZELL. Would you believe, I think Pennsylvania is included?

Mr. FLOOD. Yes, I would.

Mr. BUZZELL. Generally that is going to be very nominal in the big urban States. But the answer to your question is yes, some States, including New York and Pennsylvania, will receive less money than they did last year.

[CLERK'S NOTE: The information appears on page 643.]

LIGHTHOUSE SERVICE

Mr. FLOOD. Another language question. On page 4 of your justifications, you find this following statement:

Explanation of language change No. 5:

> The deletion of this language is a departure from the President's budget. The act of July 1, 1944, provided for, among other things, medical, surgical, and dental care for members of the former Lighthouse Service. The Health Maintenance Organization Act of 1973 signed December 29, 1973, apparently in error repealed that section of the act July 1, 1944. The Department will make a request on this matter to the committee on a future date.

Will you explain that more fully?

Mr. FORBUSH. We are sending a letter to the committee explaining why this happened. It seems that the entitlement of these lighthouse keepers was knocked out simply by a drafting error. They were codifying some legislation and it got overlooked. We checked with the authorizing committee to see if it was their intent to terminate the benefits, and if it was the intent of Congress to terminate that benefit, we would not come up with any kind of language on it. According to our inquiries, there is no such intention. So we are asking for language to correct that oversight.

PEDIATRIC PULMONARY PROGRAM

Mr. FLOOD. The distinguished lady from Louisiana, Mrs. Boggs, wanted me to ask this question.

What provisions, if any, have you made for the pediatric pulmonary program?

Mr. BUZZELL. We have 10 pediatric pulmonary centers we have been assisting for a number of years under the regional medical programs. Last year, when a decision was made to terminate the regional medical program, it was necessary to ascertain what we were going to do with the pediatric pulmonary centers. What we did was to extend their financial assistance 1 more year and were able, working with the Health Resources Administration—Dr. Endicott's agency—to provide assistance to the pulmonary centers through September of this current year.

Mr. FLOOD. What is your opinion of the impact of the program?

Mr. BUZZELL. I was going to comment on that.

We said that during this 1-year extension, we would visit each of the 10 pulmonary centers and conduct an intensive evaluation of the services they are providing. We have completed that and the report is now on its way to Dr. Edwards.

We are serving roughly 31,000 people in these centers. We are quite encouraged with the quality of the work being done.

Mr. FLOOD. You have been asked to submit a report on the program to Congress.

Mr. BUZZELL. We will be doing that.

Mr. FLOOD. From what you say, and seeing you think well of the program, we don't see anything in the budget request for it. Why is that?

Mr. BUZZELL. We don't have authorizing legislation in my agency for the pulmonary centers. They were covered under the RMP program before.

I think the thing I would like to indicate today is that they seem to be doing a good job.

Quite likely they are most properly covered by our maternal and child health appropriation. That is where the activities are similar to what we are currently doing.

Mr. FLOOD. Mr. Michel.

Mr. MICHEL. Thank you, Mr. Chairman.

HOSPITAL COST SAVINGS

Doctor, you say that a number of completed studies show reductions in hospitalizations among these center users. I wonder if you would cite and summarize the more significant of these studies for the record and also tell us how you project that $50 million in annual hospital cost savings?

Dr. BATALDEN. We will be happy to do that.

[The information follows:]

In Zwick's[1] study of the Mile Square Neighborhood Health Center in Chicago, he cited a reduction from 1,000 hospital days per thousand people to 750/1,000 over a 3-year period. Sparer[2] and Anderson found that the average number of Inpatient days for OEO enrollees who received care through four prepaid group practice plans was 600/1,000. Bellin[3] et al. found a greater reduction in hospitalization in Boston (Columbia Point) than the one cited in the Chicago study. In addition Klein,[4] et al., reported a 50 percent reduction in hospitalization among children enrolled in the Rochester Neighborhood Health Center. While we realize that such studies have limitations (for example, differences in geographic sites differences in emphasis at each center, emphasis on children in the Klein study) and that more studies need to be done, we have made some assumptions based on the findings presented.

Assuming the average rate of hospital days in neighborhood health centers is 700/1,000 (that is, between the 600/1,000 and 750/1,000 rates), we contrasted the assumed rate with the U.S. average rate for low-income people under 65 in 1968 of 1136/1,000.[2] Applying this rate and the U.S. Community hospital adjusted per diem rate of $94.61 (which is the standard average (1972) rate) to the estimated 1,195,000 persons served in our neighborhood health centers, we arrived at the following equations:

1,195,000×1,136/1,000 × $94.61	$128, 434, 967
Less 1,195,000×700/1,000×&94.61	79, 141, 265
Saved in hospitalization costs avoided	49, 293, 702

PATIENT POPULATION REDUCTION

Mr. MICHEL. I am looking at page 3 of your testimony having to do with the effectiveness of neighborhood health centers. You state these reductions are from 25 percent in general patient population in Chicago, to as much as 50 percent in Rochester.

Dr. BATALDEN. We will be happy to supply that for the record. That is the same experience we have had in the HMO program.

[The information appears above.]

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[1] Zwick, D. I., "Some Accomplishments and Findings of Neighborhood Health Centers," Milbank Memorial Fund Quarterly, vol. L, No. 4, pt. I, 387–420, October 1972.

[2] Sparer, G., and Anderson, A., "Cost of Services at Neighborhood Health Centers, a Comparative Analysis," New England Journal of Medicine, 286, 1241–1245, June 3, 1972.

[3] Bellin, S. S., Geiger, H. J., and Gibson, C. D., "Impact of Ambulatory Health Care Services on the Demand for Hospital Beds," New England Journal of Medicine, 280, 808–812, Apr. 10, 1969.

[4] Klein, M., Roghmann, J., Woodward, K., and Charney E., "The Impact of the Rochester Neighborhood Health Center on Hospitalization of Children, 1968 to1970," Pediatrics, vol. 51, No. 5, May-1973.

FAMILY HEALTH CENTER LOCATIONS

Mr. Michel. These 39 family health centers, if they only serve a total of 105,000 people, that is roughly 2,700 per center. Twenty-five of them are operational. Do we have the locations of those in the record?

Dr. Batalden. We don't have it in the record but we will supply it.

[The information follows:]

Operational Family Health Centers

Athol Memorial Hospital, Inc., Athol, Mass.
Regional Medical Center at Lubec, Lubec, Maine.
Yeshiva University—Albert Einstein College of Medicine, Bronx, N.Y.
Health Services Planning Association of Central New York, Inc., Syracuse, N.Y.
Vineland Family Health Center Corp., Vineland, N.J.
Anne Arundel County Economic Opportunity Committee, Inc., Annapolis, Md.
Monongahela Valley Association of Health Centers, Inc., Fairmont, W. Va.
West Baltimore Community Health Care Corp., Baltimore, Md.
South Philadelphia Health Action, Philadelphia, Pa.
Georgetown University Community Health Plan, Inc., Washington, D.C.
North Memphis Community Health Organization, Inc., Memphis, Tenn.
Wake Health Services, Inc., Raleigh, N.C.
Health Services Association, St. Paul, Minn.
Family Health Center, Inc., Kalamazoo, Mich.
Health Delivery Inc., Saginaw, Mich.
Group Health Association of NE Minnesota, Inc., Virginia, Minn.
Marshfield Clinic Foundation for Medical Research and Education, Marshfield, Wis.
Family Health Care Center, Crittenden Clinic, Inc., West Memphis, Ark.
Home Educational Livelihood Program, Albuquerque, N. Mex.
University of Utah, Salt Lake City, Utah.
Northern San Luis Valley Family Health Services, Center, Colo.
East Los Angeles Health Task Force, Los Angeles, Calif.
Community Health Services, Inc., Portland, Oreg.
Columbia Basin Health Association, Othello, Wash.
Lake Otis Clinic, Inc., Anchorage, Alaska.

AVERAGE COST PER FAMILY HEALTH CENTER

Mr. Michel. What is the average cost per center?

Dr. Batalden. The average cost per center of the family health center is based in part upon the continued development of those centers as well as those centers that are currently operational and providing services. So that the cost, if you simply take the number of people receiving services versus the total dollars in the program, would appear high inasmuch as these projects are currently this year completing their developmental work and moving to full operational status.

Mr. Michel. What is the difference in costs per patient served in the developmental stages as against others?

Dr. Batalden. In the development stage, they are not serving any patients.

Mr. Michel. What is the Federal contribution to an establishment of a center like this that is going to be ultimately serving according to your figures, some 2,600 or 2,700 people?

Dr. Batalden. Total developmental costs may be on the order of $750,000 to $1 million over 3 to 4 years.

Mr. Buzzell. Your question is what is the Federal contribution?

Mr. MICHEL. Yes.

Mr. BUZZELL. Essentially the total amount.

Mr. MICHEL. And the amount is roughly three-quarters of a million dollars?

Dr. BATALDEN. Over 3 to 4 years, three-quarters of a million dollars.

Mr. MICHEL. What is the maintenance cost of that once it becomes operational?

Dr. BATALDEN. It depends on the number of people who are enrolled who do not have entitlement to medicaid or do not have some other private insurance to support the costs of the service.

Mr. MICHEL. Do you envision these centers being folded into or becoming HMO centers?

Dr. BATALDEN. Yes, some of them will.

Mr. BUZZELL. To some extent. We envision their becoming self-sufficent if we are successful in getting a comprehensive health insurance program operational.

Mr. MICHEL. What indication do you have of local communities doing that in the absence of enactment of any kind of comprehensive health insurance program?

Mr. BUZZELL. Doing what?

CONTINUING FEDERAL FUNDING OF FAMILY HEALTH CENTERS

Mr. MICHEL. I should go back more fundamentally. After we have once established a family health center, what is the Federal Government's obligation for sustaining that center?

Mr. BUZZELL. It is a year-to-year obligation in the sense that as long as we have authorizing legislation and as long as we request an appropriation, we have a responsibility, I believe, to fund these centers. But there is no indefinite or nonending or open-ended obligation that I am aware of.

Mr. MICHEL. Do we have any that have been established being taken over and maintained by the local community?

Mr. BUZZELL. The local community providing the total financial assistance?

Mr. MICHEL. Yes.

Mr. BUZZELL. No, sir.

Dr. BATALDEN. That is correct. The family health center was designed to go after the working poor who weren't otherwise entitled to care support. So that is the bulk of the continuing Federal dollar once the center becomes operational.

Mr. MICHEL. There is no bar to Federal revenue-sharing funds being used for these centers, is there?

Dr. BATALDEN. That is correct.

MATERNAL AND CHILD HEALTH

Mr. MICHEL. When you refer on page 4 to the establishment of some 162 new projects in the areas of maternity and infant care, intensive care of newborns, children and youth comprehensive health care, dental health care of children, and family planning services, what are we really talking about there?

Mr. BUZZELL. The conversion from project to a formula-grant program will require many States which currently don't have the five major components of the maternal and child health program to be starting new projects and to be providing that coverage. As a consequence, a sizable number of new maternal and child health-type projects will come into existence; in large measure, some of the more rural areas although even in some of the urban settings like New Jersey.

Mr. MICHEL. Again here, what obligation does the Federal Government have after establishing them to maintain them over a period of years?

Dr. BATALDEN. They will be maintained through the formula-grant program—the maternal and child health formula grant program.

Mr. BUZZELL. The obligation, as I would view it, is one of providing financial support to the State, and secondly, a continuing responsibility to in fact ascertain that the congressional intent is carried out; that is, that the States are in fact doing with that money what the Congress required them to do.

Mr. MICHEL. Is there ever any instance of a new one being established and then phased out for one cause or another?

Dr. BATALDEN. Yes, and there have been those started by States and/or local communities without the specific Federal assistance. One of the tasks that we face in certifying State conformance to the program of project requirement will be to ascertain whether those projects that have been started by States—for example, prenatal and intensive care units that serve rural areas—whether they meet the stipulation of the statute as envisioned in title V.

Mr. BUZZELL. Do we have any estimate of how many maternal and child health projects the Federal Government has started that are no longer in existence?

Dr. BATALDEN. We can provide that for the record.

[The information follows:]

MATERNAL AND CHILD HEALTH LIST OF PROJECT GRANTEES TERMINATED SINCE PROJECT GRANT PROGRAM BEGAN

MATERNAL AND INFANT CARE PROJECTS

Massachusetts State Department of Public Health.
Arizona State Department of Health.
Pennsylvania Department of Health.

CHILDREN AND YOUTH PROJECTS

Massachusetts State Department of Public Health.
Beth Israel Hospital, Boston.
University of Iowa, Iowa City.
University of Nebraska, Omaha.

INTENSIVE CARE PROJETCS

None.

DENTAL CARE FOR CHILDREN PROJECTS

None.

INFANT MORTALITY RATE

Mr. MICHEL. On page 5, you speak of the infant mortality rate being reduced so dramatically in several cities, particularly in Albuquerque from 22.7 to 12.2, or Miami from 23.7 to 2.5, or Denver, What is the significance of citing those cities, and what was it that took place there that brought about these striking results?

Mr. Buzzell. I happen to have been to a couple of places where we have achieved some of these dramatic results. Of interest is the fact the places I went to are not the ones we cited. I went to Knoxville, Tenn., and I went to Vicksburg, Miss.

There are a number of things they have done ranging all the way from establishing an intensive care unit in a hospital, a neonatal clinic, to having a better system of emergency medical services.

Mr. Michel. Available or deliverable?

Mr. Buzzell. Available. And it is interesting, I think, what the auspices of the Tennessee Valley Association have done. The Association has worked closely with the project in Knoxville; they are able to pick up the high risk pregnancies, so-called "premies," at the site in the Appalachian hills and, with a resident or nurse in attendance on the helicopter, fly the patient into the hospital. It logically follows, I think, that the mortality rate would drop dramatically.

The same thing is applicable in the Mississippi Delta where the high risk pregnancies are in a self-service kind of an environment.

It is relatively easy to make that major breakthrough that is indicated in these kinds of statistics because basically we were not providing prenatal care, we were not providing high-risk pregnancy care.

Mr. Michel. For the record, go back and specifically tell me why, because of your having cited those cities in the record, what really is there—there has to be some reason for it.

[The information follows:]

[Clerk's note: The information appears on page 646.]

Mr. Buzzell. We believe perhaps in terms of what we submit for the record, we ought to clarify something that might be a misimpression. These are not the only cities or areas where substantial gains have been made. But I do think it is appropriate to point out in large measure——

Mr. Michel. As the chairman says, we operate like the Marine Corps here. We don't volunteer anything. You volunteered the cities and citation. There must have been a reason for that. I have to follow it because why wasn't it someplace else. Why not where you were? Was it that bad, is it not for the record?

Mr. Buzzell. That is a good point and illustrative of the good results the maternal health programs have achieved along with other people in this area.

NURSE MIDWIVES

Mr. Michel. When you talk of training nurse midwives, pediatric nurses, and other physicians' assistants, how much are we spending in that area?

Dr. Batalden. $1.5 million.

Mr. Michel. For the total program? How much per trainee? What are we spending to train an individual to become a midwife? Does anybody know?

Dr. Batalden. We can provide that. I don't have it broken out in front of me by midwife or pediatric nurse practitioner or physician assistants. We can provide that for you.

[The information follows:]

MCH—nurse midwife, pediatric cost, and so forth, training—average cost per trainee

Midwives	$4,960
Pediatric nurse practitioners	2,488
Allied health	2,238

Mr. Buzzell. We will have to clarify the record, too. The $1.5 million was broader than just the midwifery program.

Mr. Michel. My next question was what do we spend—that has been a program going on now for several years so you have an experience table, right?

Dr. Batalden. That is right.

Mr. Michel. When was that initiated?

Dr. Batalden. 1972, I think.

Mr. Michel. We know what we spent in 1972 and how many people were involved and what we did in 1973 and 1974, and what your projections are for 1975.

[The information follows:]

MCH SECTION 511 FUNDING FOR TRAINING OF NURSE MIDWIVES

		1972 actual (41 trainees)		1973 actual (34 trainees)		1974 estimate (32 trainees)		1975 estimate (32 trainees)	
Project number	Location	Faculty support	Trainee support	Faculty support	Trainee support	Faculty support	Trainee support	Faculty support	Trainee support
930	Grady Hospital, Atlanta, Ga	$54,832	$28,350	$56,017	$16,000				
940	University of Mississippi, Jackson, Miss	155,449	47,100	164,388	32,000	$164,000	$32,000	$164,000	$32,000
941	Columbia University, New York, N.Y.	80,235	87,336	107,392	97,240	107,000	97,000	107,000	97,000
Total		290,516	162,786	327,797	145,240	271,000	129,000	271,000	$129,000

HEALTH PROFESSIONAL FELLOWSHIPS

Mr. Michel. Then you speak of the 340 professional health personnel who receive specialized long-term training. How long training?

Dr. Batalden. That is the standard fellowship we are talking about in conjunction with the university-affiliated program, and those fellowships range from one year to two years, generally, in length.

Mr. Michel. Is there a maximum on the amount of the fellowship?

Dr. Batalden. No, there is none. We can give you the ranges.

Mr. Michel. Does that vary by institution?

Dr. Batalden. We can give you the ranges on that.

[The information follows:]

University Affiliated Centers Traineeship Support

Training support follows the levels established by the Department. Variances are few, are based upon personal circumstances, and are individually approved.

A. Stipend levels:

1. Postresidency clinical fellows:

(*a*) First year—up to $10,000.

(*b*) Second year—up to $12,000.

2. Post-doctoral trainees:

(*a*) No relevant postdoctoral training or experience—$6,000.

(*b*) One year of relevant postdoctoral training or experience—$6,500.

(*c*) Two or more years of relevant postdoctoral training or experience—$7,000.

3. Predoctoral experienced student support:
Months of related professional work experience or training:

	Stipend level
(*a*) Less than 12 mo	$3,000
(*b*) 12–23 mo	3,300
(*c*) 24–35 mo	3,600
(*d*) 36–47 mo	3,900
(*e*) 48 or more mo	4,200

Each full-time academic year of graduate training shall equal 12 months of related professional work experience for stipend level purposes. If a trainee or fellow has been awarded a master's degree, in a field relevant to the professional training to be undertaken, an additional $500 may be added to the stipend level for which he is otherwise qualified. The maximum predoctoral stipend may not exceed $4,700.

B. Other support:
1. Dependency allowances—$600 each.
2. Fees and tuition—actual.
3. Travel (none to or from training site)—only as related to that required for training—actual.

The primary purpose of MCH traineeship support is for training medical and allied health professionals for leadership positions in programs providing services for handicapped children, particularly those with mental retardation and other developmental disabilities. However, the support provided for the faculty and services necessary to accomplish such training generates a substantially greater amount of training than that which is directly supported. For example, a 1972 study of the Association of University Affiliated Facilities, a group of facilities providing training on an interdisciplinary basis for a variety of health and related professions, shows a total of 52,584 persons receiving training. Training ranged from postresidency fellows to subprofessionals, and from full-time, long-term, to part-time or short-term participants in seminars or workshops. This study involved 32 centers, 20 of the largest of which are supported by MCH funds.

FAMILY PLANNING

Mr. MICHEL. In the family planning area, do you have any studies at all to show the reductions in birth rate among welfare families?

Mr. BUZZELL. Dr. Shultz or Dr. Batalden.

Dr. SHULTZ. There have been no studies per se devoted to the pursuit of that in a special project area; for example, in a city where a project has been funded. However, in New York City, the experience has been, for example, that there has been a decline in the birth rate of welfare recipients during the period the project was in existence.

There are other factors operative in addition to family planning per se, because, obviously, our family planning projects do not pay for abortion services in New York City.

So a direct correlation is very difficult to accomplish, but there is some indirect evidence that, yes, there has been a reduction in the birth rate among the population being served.

These are not exclusively welfare recipients who receive the services, either, because that is not a requirement within the regulations for title X projects.

Mr. MICHEL. Are you speaking of 85 percent of all counties throughout the United States that have family planning services?

Mr. BUZZELL. Yes.

Mr. MICHEL. How about the other 15 percent? Is that achievable or desirable?

Dr. SHULTZ. Those are counties which have relatively very small populations. We are working with the State health agencies to attempt to extend services to those counties, sometimes through such devices as mobile units, but more often through encouraging private physicians in the communities where there are no organized programs.

We are really referring to organized programs or an organized physician referral program. We are encouraging the setting up of referral programs to private physicians or for private physicians on their own in those communities to provide services.

Frequently they are counties with rather limited health care services in any case, due to their small population.

NUMBER OF INDIVIDUALS SERVED

Mr. MICHEL. I am not sure whether or not in your testimony you mentioned the number of individuals being served in this family planning program throughout the country. Have we any figures on that at all?

Dr. SHULTZ. Yes, sir. In organized programs in fiscal year 1973, 3.2 million individuals received services.

Mr. MICHEL. As of what date?

Dr. SHULTZ. Fiscal year 1973, 3.2 million through organized programs. These are low-income individuals receiving services.

An additional 1.4 million individuals with low incomes received services from private physicians during this period. This does not all represent Federal——

Mr. MICHEL. How do you get that latter figure?

Dr. SHULTZ. That is based on two studies that were done. One was the family growth survey of 1970 and a projection from those 1970 figures.

Then in addition to that, a study done about the same time through Johns Hopkins University nationwide on younger people.

Mr. MICHEL. Do you anticipate in fiscal year 1974 the numbers you cited, 3.2 million and 1.4 million, would be increased?

Dr. SHULTZ. Yes, sir.

Mr. MICHEL. Significantly?

Dr. SHULTZ. Yes, sir. We anticipate a definite increase. Particularly, one of the factors which will definitely produce an increase which will carry over into 1975 is the release of the 1973 funds which were not immediately available for obligation during 1973.

Mr. MICHEL. How much was that?

Dr. SHULTZ. $30.5 million.

Mr. MICHEL. Do you want to look in your crystal ball for 1975?

Dr. SHULTZ. Due to the fact I just mentioned, we would anticipate an increase during that period, in addition to which we hope to obtain increased third-party reimbursements. Hopefully, by the end of the fiscal year, utilizing the funds available from this appropriation plus other funds, we will accomplish the goal the President set. We may not hit it exactly, but we hope to come close to it.

MATERNAL AND CHILD HEALTH FORMULA GRANTS

Mr. CONTE. Why the dramatic increase in the allocation of grants for maternal and child health services?

Mr. BUZZELL. A dramatic increase?

Mr. CONTE. The first State listed, Alabama, had $1.2 million in 1974, and now is going to $4 million. The allocation was tripled.

Mr. BUZZELL. We have to carry out the intent of Congress. We converted from a project to a formula grant program, in which the more rural States get a substantial increase.

Mr. FORBUSH. The figure you read for 1974 was funds Alabama received from the current formula grant. In 1975, it has project grants in it as well. They are really not comparable figures. Alabama probably also received project grant money in 1974. The 1974 column is limited to the formula grant figure. The 1975 column is the whole appropriation.

Mr. BUZZELL. But, as a matter of fact, they do get an increase.

Mr. FORBUSH. They got an increase as well. It is not really as big as it might show by that table.

MIGRANT HEALTH

Mr. MICHEL. Under migrant health, one of our other subcommittees, the Agriculture and Environmental Subcommittee, has been told we have roughly 216,000 or 217,000 migrant workers in this country these days formally identified. Where do you get this figure of 355,000 persons?

Dr. BATALDEN. That comes from our project. We estimate the number to be on that order. We serve the migrant worker and his family. We estimate the universe of migrant workers and their families to be about 1 million.

Mr. MICHEL. You include all the family members of the migrants when you say the total number is roughly 1 million?

Dr. BATALDEN. Right.

Mr. MICHEL. Where do you get that figure?

Dr. BATALDEN. Based on the same estimates the Department of Agriculture and the Department of Labor use, roughly about 200,000 migrant workers. It is very hard to derive accurate figures.

Mr. MICHEL. I hate to be picayunish about it, but the last couple of years I have been trying to nail this down because we have had some atrocious exaggerations of figures by well-meaning organizations. We get completely carried away with some of the things we do on the numbers game.

HEALTH MAINTENANCE ORGANIZATIONS

How many health maintenance organizations do we currently have under way?

Mr. BUZZELL. We have 45 that are currently receiving financial assistance. They are in various stages of development.

Mr. MICHEL. Is there a maximum amount of Federal contribution to an individual HMO?

Mr. BUZZELL. Depending on the period of development. The maximum allowance for feasibility studies, as I recall, is $50,000, with the possibility of an extension.

Mr. MICHEL. Then take me through the chronological steps. After the feasibility study——

Mr. BUZZELL. They are entitled to a developmental or planning grant of a maximum of——

Dr. BATALDEN. $125,000. Initial development, up to $1 million or 90 percent of the cost. Then a loan for operation deficits in the period of initial operation for a maximum of 3 years, up to $1 million in any fiscal year, not to exceed $2.5 million in the aggregate for 36 months.

Mr. MICHEL. We currently have 45?

Mr. BUZZELL. Forty-five, as part of the initial demonstration program before the HMO Act.

Mr. MICHEL. How many will be coming into their own in fiscal year 1975?

Mr. BUZZELL. I am not sure.

Do you know, Paul?

Dr. BATALDEN. We are going through an estimate right now of the exact status of these existing grantees, as we prepare to do the next round of funding under much more tightly defined conditions.

Mr. MICHEL. As you were sitting down putting together this budget, somebody had to put together these figures, and you had to add them up to come up with a request, and it was predicated on how many?

Mr. BUZZELL. No. It is slightly different. I am talking about the ones we funded in the past. We may or may not provide any more funding assistance to any one of those 45. The 1974 budget request is predicated on approximately 148 grants, contracts and loans. The 1975 budget is predicated on approximately 185 grants, contracts and loans. These awards maybe to totally new organizations that will be coming into the system in the next year.

Mr. MICHEL. Is that just by reorganization or reworking of your own planning down there, or is that by congressional mandate?

Mr. BUZZELL. Because we now have a congressional mandate, if we are the recipients of that supplemental, then we will in fact have funding to go well beyond the demonstration programs we granted in the last 3 years. For every feasibility grant we made in the last 2 or 3 years, we had to decline a large number of applicants.

Probably, quite likely, there will be many organizations now willing to embark on an HMO-kind of activity because, in fact, there is legislation to support it. Major companies, for example, have shown an interest.

NUMBER OF REQUESTS FOR HMO SUPPORT

Mr. MICHEL. I have not read through specifically all your justifications here, but what number of requests, a ball park figure, are you thinking about by way of new legislation?

Mr. BUZZELL. I expect over a thousand expressions of interest or applicants or organizations requesting feasibility assistance based on the degree of interest that has been shown to date.

Mr. MICHEL. If the committee is favorably disposed to give you what you are requesting, how many of those 1,000 requests would be favorably acted upon?

Mr. BUZZELL. In terms of feasibility studies, this coming fiscal year we are estimating on the order of 50 or 60 grants that will be funded.

The point I wanted to get across is that in spite of the fact that there is a high degree of interest, it will take a substantial amount of justification to warrant additional feasibility grants and, more significantly, the provision of a direct loan or a direct grant for the development and planning stages.

I think the degree of interest far exceeds the amount of funds available or the amount of funds that ought to be made available.

Mr. MICHEL. If you were to approve 100 or 200 or 300 or 400 rather than the 60-some——

Mr. BUZZELL. Sixty was just in the feasibility area.

Mr. MICHEL [continuing]. Does it not automatically follow that the following year's request for appropriations would bear a direct relationship by way of increases in money?

Mr. BUZZELL. Yes.

COMMUNITY HEALTH CENTERS

Mr. PATTEN. We have a community health center under the model cities program which has dental care facilities. The director of the hospital tells me it has been marvelous. They have saved the hospital money.

No one seems to mention that. It is obvious, if you listen to them, what happened. In the first place, they cut down the traffic, the load in the emergency wards, the hospital admissions. They have put their finger on problems where people should have been in the hospital.

On the overall, he claims it has helped the hospital in a lot of respects, and he put a dollar sign on it.

The only thing that bothers me with your reorganization, I am a little bit lost here. I am wondering if my little health center was financed by model cities if it will continue next year.

Mr. BUZZELL. In terms of our reorganization, there is no impact. I think you are referring to the HUD reorganization. It is conceivable and the administration is considering the possibility of those model cities neighborhood health centers, including the one you are referring to, as coming over to HEW.

Mr. PATTEN. Pursue that, will you. I have talked to a number of doctors who were very critical at first, who predicted doom. The administrator of the hospital is, I think, a capable fellow. I read in the paper that they are afraid of being phased out.

There can be no question it is needed in that area.

Mr. BUZZELL. The Department of Health, Education, and Welfare is exploring that with HUD.

Mr. PATTEN. From the little project I see it will be good, and I hope it turns out that way.

Mr. BUZZELL. Thank you.

Mr. PATTEN. Am I the leader here now?

Mr. NATCHER. I have yielded to you.

Mr. PATTEN. I think we are through on the floor.

Mr. BUZZELL. Mr. Chairman, are we still off the record?

Mr. NATCHER. Mr. Buzzell, you may take off the record what you want to.

Mr. BUZZELL. Thank you.

INFANT MORTALITY

Mr. PATTEN. In one country, I was told that one-half of all the babies born died within 1 year, a 50-percent mortality. The government people told us that epidemic disease was a big factor. The other factors, as far as economy and the like, were minor. There was very little delivery of health care as we know it.

I think I know why many of these things happen, but I do not like to be reading figures all the time which create the wrong impression. We were No. 8 in how long men live, and we are No. 22 in the world in another category.

Here some figures were used about child care, including the death rate. We had prenatal care back in the 1920's. That is nothing new. We had school nurses in all schools, including nonpublic schools, over 40 years ago.

As far as delivery of health care goes, I think a lot of our municipalities do a good job.

One thing bothers me. You list only 31 States as having a few of these child care departments, and 19 States not having them. Many programs in our State are diametrically opposite to what you find in other States. For instance, support of the public schools. That is more a local obligation through local taxes in my hometown than here in some States. We have no income tax. We rely upon the local property tax to finance public education, perhaps more than most areas. It is hard to make these comparisons.

I would think if any of you have the time, we could let the American people know a better figure, a more truthful figure, as a result of our army of doctors, hospitals, and the like, whether we are No. 22 in the world.

SCANDINAVIAN REPATRIATES

When you get a homogeneous group like Denmark, it would be too bad if they could make a better showing statistically, especially with what they do in the way of health services. In fact, it is so good that we have Swedes and Danes who, when they reach the age of 65, go back to the old country because of the medical care in Sweden and Denmark and Norway. They get our social security and a few other benefits, but go back to the old country when they are worried a little bit about their health because they can do better.

With our population, I do not think it fair to list everybody as being alike and being forever hit by figures that we are 22d in the world. I think there should be a fair comparison. I do not like the statistics that are usually put forth. I do not think it is fair to your Department or fair to our people throughout the country the way those statistics are arranged.

Do I make myself clear?

Mr. BUZZELL. Yes, you do, Mr. Patten.

Mr. PATTEN. For instance, you are to have a billion dollars, a thousand million. Since I am in Congress, I am proud that it is many times what it was when I started in Congress. I would like to feel I am a factor in developing some of this support.

The truth is, looking at your reorganization, your budget might be five times what it was in 1965.

Mr. BUZZELL. I think your point is well taken. We certainly have a requirement to do a better and better job with the moneys made available by this committee and the Senate. We are spending a substantial sum of money on health care, and it is our responsibility to make sure we provide the best care we can.

Mr. PATTEN. Let us put out a statement. It is not fair to compare the whole of the United States with some countries. It does not tell me anything if you are going to compare with a country like Denmark, with 2½ million people.

I do not think we should be listed with countries like Denmark. I would like to see a comparison that was meaningful for a mixed population like ours, and make a comparison that would be more valid than the way we list a lot of these life expectancy and mortality figures. I do not think they mean much at present, and it is not fair to us in the Congress and it is not fair to you in the department.

When you asked for $65 million on the supplemental, I attended a community health planning group meeting and our doctors were the ones who called the meeting. I was ashamed of myself when I found their criticism of what we should do in the town and we were not doing. The Federal Government had nothing to do with it. We were speaking as citizens of our home town.

My local hospital is on the front pages, projecting a plan of $13 million for expansion. We had drives for the hospital of $1 or $3 million for an addition. They now have an expansion plan of $13 million.

I read in the paper that this group has a plan for a $9 million expansion in a prosperous area. We have another group in the county that has no hospital and plans to start one.

I was talking with people the other day, some of whom are in the room, and they say they are going back home to move for better medical facilities in their town, which grew from 4,000 in 1947, after the war, to 50,000 today. There is no hospital. It is a beautiful town, a suburb. If they take a look, they are lacking in many things.

One of the union representatives said after what they heard here, they were going back home to agitate for better health facilities in their beautiful town.

As you work in these programs, especially your community health programs and family planning, I know they are bread-and-butter issues to me in my district. If this budget has been cut or services have been omitted, I will be hearing about it loud and clear from good people. Don't think I won't.

You have a big responsibility.

Mr. BUZZELL. Thank you very much.

TWO-YEAR GRANT AWARDS

Mr. NATCHER. This morning the chairman asked you whether any of the fiscal year 1973 funds for community health centers which were released recently were being used to fund 2-year grants. Your answer to the chairman's question was "No." Are you sure about that?

Mr. BUZZELL. No. I would like to correct the record. As I understand it, some of them are. I am told it is on the order of $2 million.

Mr. NATCHER. So, some are used for what?

Mr. BUZZELL. For 2-year funding.

Do you want to add anything, Paul?

Mr. NATCHER. Go ahead. This will clear the record.

Dr. BATALDEN. The bulk of these funds are being used to provide additional services to selected family health centers. Approximately $3 million will be used for an additional year's funding in seven of the projects.

PHYSICIANS' ASSISTANTS

Mr. NATCHER. Mr. Buzzell, in the request now before the committee, do we have funds for physicians' helpers?

Mr. BUZZELL. For physicians' helpers. You are referring to the physician extenders. Yes, a limited amount.

Mr. NATCHER. What is the terminology?

Mr. BUZZELL. I use the term "physician extenders" or "physician assistants."

Mr. NATCHER. You say a limited amount. How much?

Mr. BUZZELL. Under training funds, $1.5 million.

Mr. NATCHER. A number of universities and colleges throughout the United States I believe have this program, is that not correct?

Mr. BUZZELL. Yes.

Mr. NATCHER. Here in Washington at George Washington they have a program. As I understand it, most of the colleges and universities take only a limited number, 25, 30, or 40. Is that not correct?

Mr. BUZZELL. Yes.

Mr. NATCHER. How much of this program do you fund? Assume George Washington University here in Washington. Is this a grant, a matching program, or what is it?

Dr. BATALDEN. These are training grants that are provided to the institution under the maternal and child health training grant authority, section 511 of title V.

Mr. NATCHER. On what basis? Is this an equal matching proposition, or how is it handled?

Mr. BUZZELL. As I recall, Paul, that is a direct grant.

Dr. BATALDEN. Yes, it is.

Mr. BUZZELL. Your question in reference to the one here in Washington——

Mr. NATCHER. Any one of them. The one here in Washington, for instance.

Mr. BUZZELL. I would like to submit for the record information on any one of these examples, including this one, because I do not have the data with me.

Dr. BATALDEN. We have a whole list of the projects that are supported under that $1.5 million.

Mr. NATCHER. You may submit that to Mr. Neil, and he will insert in the record the pertinent parts.

When you get the transcript back, give us a little better explanation as to how this program works.

Dr. BATALDEN. Yes, sir.

[The information follows:]

MCH SECTION 511 FUNDING FOR TRAINING OF PEDIATRIC NURSE PRACTITIONERS

Project Number	Location	1972 Actual		1973 Actual		1974 Estimate		1975 Estimate	
		Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support
935	Univ. of Calif. San Francisco	$ 16,451	$-----	$227,489	$ 53,279	$236,183	$ 41,230	$236,000	$41,000
937	Univ. of Conn. Hartford, Conn.	83,482	9,600	85,884	7,200	86,000	7,000	86,000	7,000
942	Yale Univ. New Haven, Conn.	------	117,425	------	------	------	------	------	------
943	Emory Univ. Atlanta, Ga.	92,393	33,000	92,393	53,000	92,000	53,000	92,000	53,000
933	Univ. of Iowa Iowa City	55,220	7,420	55,340	7,300	55,000	7,000	55,000	7,000
932	Univ. of Md. College Park, Md.	69,588	55,371	92,580	57,390	93,000	57,000	93,000	57,000
929	Harvard Med. School Boston, Mass.	37,860	------	70,659	------	71,000	------	71,000	------
938	Univ. of Wash. Seattle	73,741	18,900	73,599	18,900	74,000	18,900	74,000	19,000
TOTAL		$428,735	$241,746	$697,944	$197,069	$707,183	$184,130	$707,000	$184,000
Total Trainees		68		76		92		92	

~~Pages 2577~~
and 2611

MCH SECTION 511 FUNDING FOR TRAINING OF NURSE MIDWIVES

Project Number	Location	1972 Actual		1973 Actual		1974 Estimate		1975 Estimate	
		Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support
930	Grady Hospital Atlanta, Ga.	$ 54,832	$ 28,350	$ 56,017	$ 16,000	------	------	------	------
940	Univ. of Miss. Jackson, Miss.	155,449	47,100	164,388	32,000	$164,000	$ 32,000	$164,000	$32,000
941	Columbia Univ. New York, N.Y.	80,235	87,336	107,392	97,240	107,000	97,000	107,000	97,000
TOTAL		$290,516	$162,786	$327,797	$145,240	$271,000	$129,000	$271,000	$129,000
Number of Trainees		41		34		32		32	

MCH SECTION 511 FUNDING FOR TRAINING OF OTHER ALLIED HEALTH PERSONNEL

Project Number	Location	1972 Actual		1973 Actual		1974 Estimate		1975 Estimate	
		Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support	Faculty Support	Trainee Support
931	Univ. of Alabama Tuscaloosa (Nutrition)	$ 27,291	$ 9,716	$ 33,464	$ 12,536	$ 33,000	$ 13,000	$ 33,000	$ 13,00
936	Boston Univ. Boston (Occup. Ther.)	42,771	22,450	34,177	27,450	34,000	27,000	34,000	27,00
939	Univ. of N.C. Chapel Hill (Phys. Ther.)	45,012	-0-	60,412	-0-	59,000	1,000	59,000	1,00
934	Va. Commonwealth Univ. Richmond (Dental Hygienst)	55,907	6,000	54,076	6,000	54,000	6,000	54,000	6,00
TOTAL		$170,981	$38,166	$182,129	$45,986	$180,000	$47,000	$180,000	$47,00
Total Trainees		20		20		26		26	

PRIVATE INDUSTRY EFFORTS

Mr. **Patten**. Private industry has spent enormous sums of money. I know who financed and worked in Congress to get some of the programs for the capitation grants for the nurses to help our community college have a little nursing school, and things of that type. Private industry put up a lot of money. We made brochures. We are the ones who tried to educate the Members of Congress, not to mention the Department and the White House, as to the need.

When you are spending $1.5 million in this area, I am under the impression we always did things like this. We always had a nursing school with our hospitals. St. Peters always had a nursing school. You are not biting off the whole thing.

Mr. **Buzzell**. That is correct.

Mr. **Patten**. Training goes on in a lot of other areas that are not helped by the Federal Government.

The medical profession itself, pharmaceuticals and others have been aware of this, and they have put forth tremendous sums of money in this area. I do not know how it would compare with the Federal effort.

Mr. **Buzzell**. The expenditures that we are making in this area of training midwives and nurse practitioners is not a very big sum of money. I think your point is well taken.

Mr. **Patten**. This is all brand new.

Mr. **Buzzell**. That is right.

Mr. **Natcher**. Mr. Shriver.

UNDERSERVED RURAL AREAS

Mr. **Shriver**. Several places in your justifications you mentioned that specific programs under your jurisdiction are supposed to improve the availability of health services in underserved areas. I am wondering if you would provide for the record a summary of these efforts and the amounts requested for them. That would be helpful to the Members of Congress, especially those who are from the more rural parts of the country. I know I have received requests from my State asking what the Government is doing.

Mr. **Buzzell**. We will be glad to do that, Mr. Congressman.

[The information follows:]

SUMMARY OF BUREAU OF COMMUNITY HEALTH SERVICES—RURAL HEALTH ACTIVITIES

Program and estimated level of rural funding	Major activity	Rural activities
Community health centers ($36,600,000 in neighborhood health centers and $5,300,000 in family health centers).	Ambulatory health care programs providing a broad range of health care services designed to meet needs of the target population.	28 of a total of 118 neighborhood health centers and 22 of 39 family health centers are serving rural areas.
Migrant health ($23,750,000)	Migrant and seasonal farmworkers and their families provided access to health care services.	103 projects are serving rural areas.
Maternal and child health ($25,500,000 for project grants. It is not possible to estimate this amount for formula grants. However, legislation requires emphasis on rural areas and this is taken care of in the maternal and child health formula by weighting rural live births by a factor of 2 to 1 urban live births).	Preventive health services provided to mothers and children and diagnostic, treatment and followup care provided to children with crippling or other handicapping illnesses.	16 of 61 maternal and infant care projects, 8 of 62 children and youth projects and 5 of 18 dental projects are located in rural areas. (In addition 56 formula grants for maternal and child health services and 56 formula grants for crippled children's services support activities, many of which are in rural areas.
Family planning ($19,500,000)	Voluntary family planning services are made available to anyone desiring such services, particularly those unable to pay.	271 of 350 grants provide for services in rural areas.
National Health Service Corps ($7,800,000).	Small teams of health professionals are placed in health manpower shortage areas.	146 of 183 communities are in rural areas.
Health maintenance organizations ($10,000,000).	Comprehensive health services (ambulatory and inpatient) are provided on a prepaid capitation basis.	Statute (Public Law 93-222) requires 20 percent set aside of a fiscal year's funds to go to rural areas.
Grants for comprehensive public health services.	Formula grants to assist States in establishing adequate public health services.	States use part of the funds to support activities which help rural areas, but there is no way to estimate rural versus urban.

MATERNAL AND CHILD HEALTH

Mr. SHRIVER. I notice that the shift to an all-formula grant basis for maternal and child health services results in a substantial increase in the amount of funds for the State of Kansas and other States, at least according to the statement on page 85 of the justification book. Kansas would get about $1 million more and many other States considerably more in the 1975 estimate.

On page 33, you have a numerical breakdown of new projects required by law in some States as a result of this shift to all-formula grants in maternal and child health services.

Mr. BUZZELL. Could I make one point, Mr. Shriver, because it does impact your State.

In this year of converting from project to formula grants, and with the release of funds, it is a very complex equation as to how much each State will receive. I wanted to be very sure today that we did not incorrectly leave you with the impression that your State was going to receive a substantial increase.

Mr. SHRIVER. It looks that way to me.

Mr. BUZZELL. That is, I am afraid, incorrect. We will supply to you, either at your office or for the record, more exact data on that.

Mr. SHRIVER. The cost increases shown in the estimates for 1975 affect all members of the subcommittee.

Mr. BUZZELL. I will be glad to provide that information.

Mr. PATTEN. We cannot be equal in everything. Kansas got the gasoline and we did not get it in the allocations. Under your program, if you give Kansas a little bit less, it may be equitable.

[CLERK'S NOTE. The information appears on page 643.]

Mr. Shriver. Does the "hold harmless" provision affecting this change in the maternal and child health program expire after fiscal 1975?

Mr. Buzzell. Yes. We are trying to match two objectives that the Congress passed, trying to balance two objectives of the Congress, one of which was to hold harmless some of the States, the ones that heretofore were getting the bulk of project money, while at the same time taking recognition of the fact that many of the States, particularly the rural States, were not providing all of these services in the maternal and child health program, and thus had to have increased funds. The balancing of the two objectives is giving us some difficulty.

Mr. Shriver. Are the funds requested for the support of university-affiliated centers for the maternally retarded sufficient to fund these centers at their 1974 operating level?

Mr. Buzzell. Yes, the funds are adequate for that purpose.

NATIONAL HEALTH SERVICE CORPS

Mr. Shriver. Would you list for the record the communities which are or will be benefiting from the National Health Service Corps personnel in fiscal year 1975?

Mr. Buzzell. Yes, we will.

Mr. Shriver. Or for whatever period you have that information.

Mr. Buzzell. I think the way you asked for it is the best way to do it. We know with a high degree of certainty where we will be in July of 1974, and we will use that as our point of reference. Thank you.

[The information follows:]

Can you provide a list of NHSC communities that will be staffed as of July 1974?

The following list will show the NHSC communities that will be staffed as of July 31, 1974. In addition, we are in the process of matching 35 to 40 potential assignees to NHSC communities for assignment in the first quarter of fiscal year 1975.

- Alabama:
  - Cherokee.
  - Goodwater.
  - Red Bay.
- Alaska:
  - Anchorage.
  - Unalaska.
  - Yakutat.
  - Galena.
- Arizona:
  - Benson.
  - Marana.
- Arkansas:
  - Lewisville.
  - Marianna.
- California:
  - Hollister.
  - Isleton.
  - Livingston.
  - Orland.
  - Banning.
  - Bishop.
  - Brentwood.
  - Etna.
  - Eureka.
- California—Continued
  - Rio Linda.
  - San Francisco.
  - Union City.
  - Brownsville.
  - Guerneville.
- Colorado:
  - Saguache.
  - Westcliffe.
  - Pagosa Springs.
  - Yuma.
  - Rangely.
  - Rocky Ford.
  - Sterling.
  - Walsenburg.
  - Canon City.
- Connecticut: Enfield.
- Florida:
  - Immokalee.
  - Cross City.
  - Belle Glade.
  - Branford.
  - Frostproof.
- Georgia: Atlanta.

- Idaho: Nampa.
- Illinois:
  - Rock Island.
  - Waukegan.
- Indiana:
  - Columbus.
  - Indianapolis.
  - Brownstown.
  - Rushville.
  - Liberty.
- Iowa: Eldora.
- Kansas:
  - Haven.
  - Louisburg.
- Kentucky:
  - Louisville.
  - Buckhorn.
- Louisiana:
  - New Orleans-Algiers-Fischer.
  - Plain Dealing.
  - New Orleans-St. Bernard.
- Maine:
  - Lubec.
  - Calais.
- Maryland:
  - Baltimore-Homestead-Montebello.
  - Baltimore-O'Donnell Heights.
- Michigan:
  - Decatur.
  - Kalamazoo.
  - Newberry.
- Minnesota: Clinton.
- Mississippi:
  - Philadelphia.
  - Hickory.
  - Lexington.
  - Dekalb.
  - Tehula.
- Missouri:
  - Kansas City.
  - Winona.
- Montana:
  - Chester.
  - Shelby.
  - Terry.
  - West Yellowstone.
  - Superior.
  - Fort Benton.
  - Kalispell.
  - Scobey.
- Nebraska:
  - Bassett.
  - North Bend.
  - Rushville.
- New Hampshire:
  - Colebrook.
  - Littleton.
  - Gorham.
  - North Conway.
  - Newport.
- New Mexico:
  - Gallup.
  - Las Cruces.
  - Jemez Springs.
  - Santa Fe.
  - Tierra Amarilla.
- New York:
  - Wellsville.
  - Boonville.
  - Cato.
  - Utica.
  - West Winfield.
  - Mariners Harbor.
  - Perkinsville.
  - Rochester.
  - Richmondville.
  - South Bronx-Montefiore.
  - Walworth.
- North Carolina:
  - Plymouth.
  - Maxton.
  - North Wilkesboro.
- North Dakota:
  - Elgin.
  - Gackle.
  - LaMoure.
- Oklahoma: Ringling.
- Oregon:
  - Brookings.
  - Woodburn.
  - Condon.
- Pennsylvania:
  - Broad Top City.
  - White Haven.
  - East Brady.
  - Alexandria.
  - Pittsburgh-Hazelwood.
  - Orbisonia.
  - Spring Mills.
  - West Grove.
  - Philadelphia-Philadelphia Medical Center.
  - Philadelphia-People's Neighborhood Medical Center.
  - Philadelphia-Episcopal Hospital.
  - Windsor.
  - South Gibson.
  - Holstead.
  - Philadelphia-St. Christopher Hospital.
  - Pittsburgh-Mercy Hospital.
  - Snow Shoe.
  - Warminster Heights.
- South Carolina:
  - Beaufort.
  - McCormick.
- South Dakota:
  - Faulkton.
  - Martin.
- Tennessee:
  - Monterey.
  - Parsons.
  - Surgoinsville.
  - Tazewell.
  - Wartburg.
  - Rutledge.
  - Spring City.
  - Kingston.
  - Celina.
  - Petros.
- Texas:
  - Claude.

- Texas—continued
  - LaMarque.
  - Harlingen.
  - Rio Grande City.
  - Waelder.
  - Eagle Pass.
- Utah: Tooele.
- Vermont:
  - Bristol.
  - Hardwick.
  - Island Pond.
  - Lyndonville.
  - Waterbury.
- Virginia:
  - Grundy.
  - Haysi.
  - Louisa.
  - Newport News.
- Washington:
  - Darrington.
- Washington—continued
  - Grand Coulee.
  - Ritzville.
  - Seattle.
  - Union.
  - Stevenson.
- West Virginia:
  - Blacksville.
  - West Union.
  - Glenville.
  - Harts.
  - Union.
  - War.
- Wisconsin:
  - LaFarge and Soldiers Grove.
  - Neopit.
- Wyoming:
  - Lusk.
  - Sundance.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. Shriver. You mention that the Bureau of Quality Assurance in your administration has operational responsibility for the implementation of the professional standards review organization program, but the budget request comes under the Office of the Assistant Secretary for Health. Is that a temporary arrangement until the program gets moving? Why should it be spread around?

Mr. Buzzell. The answer is that it is the intent of the Assistant Secretary for Health that that be a temporary arrangement. In the passage of the legislation, emphasis was placed on wanting this program located at the highest possible level, and had it located in the office of the Assistant Secretary for Health.

As a consequence, in trying to follow that mandate, the Department has established that the Deputy Assistant Secretary for Health, Dr. Henry E. Simmons, would have the responsibility for the PSRO program.

Once it becomes fully operational, it is our intent to have the total responsibility with Dr. Goran in the Bureau of Quality Assurance.

PUBLIC HEALTH SERVICE HOSPITALS

Mr. Shriver. We have heard a lot about the closing of Public Health Service hospitals. I take it you have given up on that.

Mr. Buzzell. We are very anxious to follow not only the intent of the Congress but the law, and the law is quite explicit that in order to close one of these facilities we need the concurrence of Congress to do that. As a consequence, it is our posture now that if we were to ascertain that one of the hospitals was no longer needed, we would in fact present a plan to Congress requesting concurrence to close that facility.

Mr. Shriver. Would it take quite a bit of money to make these facilities feasible or economic?

Mr. Buzzell. We are putting a sum of money into the repair and improvement of some of these facilities, basically to bring them up to standard. In many instances these facilities are economically competitive for a number of reasons. They do not have the capital improvement costs anymore. They do not have depreciation. The salaries of the personnel there are not very high. They are competitive.

LOW-IMPACT MIGRANT AREAS

Mr. Shriver. What special approaches are you planning in fiscal year 1975 to meet the health needs of migrants in low-impact areas? You are requesting an increase of only $250,000.

Mr. Buzzell. Generally speaking, the approaches are not special approaches. It is more in line with the need to work more closely with the State in order to see that the State provides more assistance, in order that the medicaid programs in the various States are made available to the migrants. The hospital demonstration project we talked about this morning is in fact a special approach, I suppose. We are attempting to provide hospitalized coverage for the migrants.

It is through that application of technical assistance, for example, using our Center for Disease Control, providing training assistance to the States in order that they can in fact more effectively enforce the standards or see that the migrant camps in both low- and high-impact areas are in fact administered better for the patients.

I do not want to leave the committee with the impression that we have a special program or funding that will do something different in the migrant health area.

Mr. Shriver. You have been a helpful and a good witness.

Mr. Buzzell. Thank you very much.

TUSKEGEE STUDY

Mr. Conte. How will services be provided to the Tuskegee study survivors—by reimbursing their own physicians or by PHS personnel and facilities?

Dr. Scencer. The surviving participants have been provided with a card which permits them to receive medical services from the health care provider of his choice. Bills are paid directly by the Public Health Service.

NATIONAL HEALTH SERVICE CORPS

Mr. Conte. How many States have National Health Service Corps teams in them?

Mr. Buzzell. As of March 31, 1974, 43 States and the District of Columbia have teams.

[The States are as follows:]

1. Alabama.
2. Alaska.
3. Arizona.
4. Arkansas.
5. California.
6. Colorado.
7. Connecticut.
8. District of Columbia.
9. Florida.
10. Georgia.
11. Idaho.
12. Illinois.
13. Indiana.
14. Kansas.
15. Kentucky.
16. Louisiana.
17. Maine.
18. Maryland.
19. Michigan.
20. Minnesota.
21. Mississippi.
22. Missouri.
23. Montana.
24. Nebraska.
25. New Hampshire.
26. New Mexico.
27. New York.
28. North Carolina.
29. North Dakota.
30. Ohio.
31. Oklahoma.
32. Oregon.
33. Pennsylvania.
34. South Carolina.
35. South Dakota.
36. Tennessee.
37. Texas.
38. Utah.
39. Vermont.
40. Virginia.
41. Washington.
42. West Virginia.
43. Wisconsin.
44. Wyoming.

Mr. CONTE. What is the process by which an area gets a National Health Service Corps assignee?

Mr. BUZZELL. The Secretary designates areas having critical health manpower shortages under provisions of Public Law 92–585. After a community has been designated, the National Health Service Corps provides technical assistance to the communities in preparing applications for the assignees. Once the application is completed it is reviewed by the regional health administrator and his staff and is either approved, approved with conditions, or disapproved. The conditions may require the submission of additional information on pertinent items or require that the comments from the comprehensive health planning agencies and local governments be received prior to final approval.

Once the community is approved, recruitment for assignees begins both in the regional office and nationally. Potential assignees are given a choice of some six different sites from which they choose one to establish their practice. A community although approved may not receive a professional assignee for some time, since the election to serve in a given community rests with the assignee himself. Generally speaking, however, the procedure outlined, with numerous added facets of activity, will accomplish the assignment of a National Health Service Corps professional to a community.

FAMILY HEALTH CENTERS

Mr. CONTE. You mention the possibility of converting some of the family health centers into HMO's. Is this going to be possible for any of the neighborhood health centers, too?

Mr. BUZZELL. Yes; in the sense that some neighborhood health centers will be offering services on a prepaid capitation basis which incorporates some of the basic HMO concepts. But as I said in relation to family health centers, this does not mean we will be refunding them as HMO's under the new legislation.

Mr. CONTE. What is the enrollment range of the family health centers and what have you found is the minimum population for which such a service can be economically set up?

Mr. BUZZELL. Based on the last quarterly report, enrollment ranges from 51 in a program just beginning the marketing and enrollment process, to 5,000 in a project which has been operating with a contract arrangement involving the State medicaid program and other private health plans.

We don't think we have sufficient operating experience yet to say what the minimum enrollment is to support a family health center. The original assumption was that 5,000 enrollees was the minimum, but we will be looking at this along with many of the other factors which affect the economic viability of a center.

NEIGHBORHOOD HEALTH CENTERS

Mr. CONTE. For the neighborhood centers, do you have an average annual cost per patient served?

Mr. BUZZELL. At the chairman's request, this information will be supplied for the record.

[Clerk's note: The information appears on pages 80 and 81 of this volume.]

Mr. CONTE. Neighborhood centers are about 1 in 4 of their target populations. Is the capacity of the centers the limiting factor? Do you have any estimate of the number of children in the target populations not served yet?

Mr. BUZZELL. It varies with the center but in some cases the capacity of the center would be the limiting factor. However, the term "target population" generally refers to the number of persons living within the geographic area which the center itself feels might avail themselves of their services. Of course, we would never expect a center to fully serve all of the "target population" because of the very nature of the medical market in every community and the reality that some persons will go to other sources of medical care for their health needs.

We don't have specific data on the total "target population" by age, sex, and other factors. Of the 1.2 million persons served by the centers in 1974, we estimate 40 percent or 480,000 to be under age 15.

MATERNAL AND CHILD HEALTH

Mr. CONTE. You're going to redistribute $25 million to satisfy the hold harmless requirement of the maternal and child health project grant extension legislation. Where is the $25 million going to be transferred from?

Mr. BUZZELL. The $25 million is comprised of $7 million which was made available in 1974 and continues under section 516 and $18 million which was previously requested under section 503. Together, this totals the $25 million to be distributed to States under section 516 authority in 1975.

This does not completely satisfy the hold harmless provision of section 516 but combined with other actions the Department is planning, it will minimize the impact of the conversion from project to formula grants.

Mr. CONTE. Mandatory maternal and child health service packages are going to require your setting up as many new programs as you already have in existence. How are you going to do this without additional funds?

Mr. BUZZELL. Under the 1975 maternal and child health program, States have the responsibility for establishing projects in each of five service areas. However, based on information from States, the projects now supported will continue to receive assistance through the State formula grant. But in States where any of the five service areas are not now provided, it will be necessary for the States to make such arrangements. We estimate this to require 162 new State initiatives.

Through distribution of $25 million under section 516 and the availability in 1975 of $10,472,000 in released project grant funds, the States and projects will have nearly as much available to them in 1975 as in 1973. The funds available under the formula distribution in 1975 will provide for continuation of existing projects and will allow States to initiate new projects.

TRAINING OF NURSE MIDWIVES

Mr. CONTE. How much are you spending in 1974 on training nurse midwives and other physician assistants? How much in 1975? Will you compare the number of trainees for the 2 years?

Mr. Buzzell. Under section 511, $1,500,000 is being spent in 1974. The same amount will be spent in 1975. The same number of health personnel, that is 150, will receive long-term training under this program in both years. In addition, approximately 60 such personnel will receive short-term training.

Mr. Natcher. We want to thank you and your associates, Mr. Buzzell, for appearing before our committee at this time in behalf of your budget request for fiscal year 1975 for the Health Services Administration.

It has been a good hearing, and we want to thank you.

Mr. Buzzell. Thank you very much.

Mr. Natcher. The committee will adjourn until 10 o'clock in the morning.

JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services

Amounts Available for Obligation[1/]

	1974 Revised	1975
Appropriation	$860,280,000	$896,405,000
Proposed supplementals*	67,470,000	---
Subtotal, adjusted appropriation	927,750,000	---
Real transfers to:		
"Departmental management for department wide reduction in public affairs"	-204,000	---
"General Services Administration"	-168,000	---
Comparative transfers to:		
"Departmental management"	-469,000	---
"Office of the Assistant Secretary for Health for administrative support activities"	-6,447,000	---
"Office of Human Development"	-600,000	---
"Health Resources"	-11,196,000	---
"Alcoholism, Drug Abuse and Mental Health Administration"	-42,000	---
"Office of the Director, National Institutes of Health"	-47,000	---
Comparative transfer from:		
"Office of the Assistant Secretary for Health"	+4,100,000	---
Subtotal, budget authority	912,677,000	896,405,000
Receipts and reimbursements from:		
"Federal funds"	19,597,000	19,644,000
"Trust funds"	5,613,000	5,774,000
"Non-Federal sources"	568,000	568,000
Unobligated balance, start of year	---	5,463,000
Unobligated balance, transferred	3,213,000	---
Unobligated balance, end of year	-5,463,000	-1,736,000
Total, 1974 base obligations	936,205,000	926,118,000
Unobligated balance, restored	+46,881,000	---
Total, obligations	983,086,000	926,118,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1974 - $5,566,000; 1975 - $6,506,000.

* Including pay transfer (+$2,470,000).

Summary of Changes

1974 Estimated obligations	$983,086,000
1975 Estimated obligations	926,118,000
Net change	-56,968,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. 1974 Annualization of October 1973 pay raise	---	---	---	$1,458,000
2. Within grade and longevity increases	---	---	---	1,668,000
3. One extra day of pay	---	---	---	232,000
4. Social Security contribution	---	---	---	46,000
5. Increases for DHEW Working Capital Fund, HSA Service and Supply Fund, and FTS and FEC charges	---	---	---	481,000
6. Contract services and medical care and supply price increases	---	---	---	1,458,000
7. Payment to General Services Administration for rent	---	---	---	4,529,000
8. Annualization for 100 new positions for Health Maintenance Organizations	---	---	---	1,784,000
Subtotal	---	---	---	11,656,000
B. Program:				
1. Community health services:				
(c) Maternal and child health:				
(1) Grants to States	---	$132,678,000	---	111,273,000
(e) Migrant health	---	23,750,000	---	250,000
(f) Health maintenance organizations	100	65,000,000	25	416,000
(g) National health service corps	405	9,849,000	146	200,000
3. Patient care and special health services:				
(a) Patient care	5,084	109,914,000	---	1,600,000
4. Buildings and facilities	---	---	---	5,027,000
5. Program management	893	33,132,000	10	50,000
Subtotal	---	---	181	118,816,000
Total, increases	---	---	181	130,472,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Decreases:				
A. Built-in:				
1. Non-recurring costs in 1974	---	---	---	-$6,354,000
B. Program:				
1. Community health services:				
(a) Community health centers	---	$211,500,000	---	-11,100,000
(c) Maternal and child health:				
(2) Project grants......	---	121,745,000	---	-121,745,000
(d) Family planning.........	---	131,024,000	---	-30,409,000
(f) Health maintenance organizations.........	100	65,000,000	---	-5,000,000
4. Buildings and facilities....	---	12,000,000	---	-5,000,000
5. Program management..........	893	33,132,000	---	-832,000
Subtotal..	---	---	---	-181,086,000
Total, decreases........	---	---	---	-187,440,000
Total, net change...............	---	---	181	-56,968,000

Explanation of Changes

Increases:

A. Built-in:

An increase of $11,656,000 is for mandatory items. Of this amount, $1,458,000 is for 1974 annualization of the October 1973 pay raise; $1,668,000 is for additional costs of within grade and longevity increases; $232,000 for the cost of one extra day of pay; $46,000 increase in Social Security contributions; $481,000 for DHEW Working Capital Fund, HSA Service and Supply Fund, FTS and FEC charges; $1,458,000 for contract services and medical care and supply price increases; $4,529,000 for payment to GSA for rent; and $1,784,000 for annualization for the 100 new positions for Health Maintenance Organizations.

B. Program:

1. Community health services:

(c) Maternal and child health:

(1) Grants to States - The increase of $111,273,000 reflects the incorporation in 1975 of project grant funds into the formula grant program. This is in accordance with P.L. 93-53.

(e) Migrant health - The increase of $250,000 supports the development of special approaches to meet the needs of migrants in low-impact areas.

(f) Health maintenance organizations - The increase of $416,000 supports 25 new positions in 1975.

(g) National health service corps - The increase of $200,000 supports 146 new positions in 1975.

3. Patient care and special health services:

(a) Patient care - The increase of $1,600,000 in 1975 is requested to provide health care to the participants in the 1932 Public Health Service study of untreated syphilis at Tuskegee.

4. Buildings and facilities - The increase of $5,027,000 provides for repairs and improvement projects for the PHS outpatient clinics and the PHS Leprosarium at Carville, Louisiana.

5. Program management - The increase of $50,000 supports 10 new positions for the National health service corps in 1975.

Decreases:

A. Built-in:

The decrease of $6,354,000 is for non-recurring costs for the following items: $2,200,000 for Health maintenance organizations technical assistance contracts; $1,043,000 for National health service corps contracts resulting from the additional $2,000,000 appropriated in 1974 by P.L. 93-192; $1,277,000 for drugs and medical supplies for PHS hospitals resulting from the additional $3,000,000 appropriated in 1974 by P.L. 93-192; $1,729,000 for project contracts, and $105,000 for equipment and other contractual services in program management

B. Program:

1. Community health services:

(a) Community health centers - The decrease of $11,100,000 is attributed to: $5,100,000 for expected savings due to improved project management and $6,000,000 for one-time costs associated with the release in 1974 of the 1973 impounded funds.

(c) Maternal and child health:

(2) Project grants - The decrease of $121,745,000 reflects: $111,273,000 for the incorporation in 1975 of project grant funds (after one year of extension) into the formula grant program, in accordance with P.L. 93-53 and $10,472,000 for one-time costs associated with the release in 1974 of the 1973 impounded funds.

(d) Family planning - The decrease of $30,409,000 is for the one-time costs associated with the release in 1974 of the 1973 impounded funds.

(f) Health maintenance organizations - The $5,000,000 net decrease results from a $20,000,000 decrease for loans and loan guarantees and an increase of $15,000,000 for grants and contracts.

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4. Buildings and facilities - The decrease of $12,000,000 represents 1974 obligations for repair and modernization of the PHS hospitals.

5. Program management - The decrease of $832,000 for costs associated with the 53 position reduction in Maternal and Child Health reflects the incorporation of the project grant program into the State formula grant program in 1975 and the transfer to the States of additional responsibility for technical assistance, consultation, and the review and monitoring of project proposals and operations.

Obligations by Activity

Page Ref.		1974 Base*		1975 Estimate		Increase or Decrease		
		Pos.	Amount	Pos.	Amount	Pos.	Amount	
21	Community health services:							
24	(a) Community health centers.........	---	$205,500,000 (211,500,000)	---	$200,400,000	---	-$5,100,000	A/
27	(b) Comprehensive health grants to States.......	63	90,000,000	63	90,000,000	---	---	
29	(c) Maternal and child health:							
31	(1) Grants to States......	---	132,678,000	---	243,951,000	---	+111,273,000	B/
	(2) Project grants......	---	111,273,000 (121,745,000)	---	---	---	-111,273,000	B/
34	(3) Research and training....	---	21,917,000	---	21,917,000	---	---	
	Subtotal...	---	265,868,000 (276,340,000)	---	265,868,000	---	---	
36	(d) Family planning.	---	100,615,000 (131,024,000)	---	100,615,000	---	---	
39	(e) Migrant health..	---	23,750,000	---	24,000,000	---	+250,000	C/
41	(f) Health maintenance organizations...	100	65,000,000	125	60,000,000	+25	-5,000,000	D/
45	(g) National health service corps...	405	9,849,000	551	9,255,000	+146	-594,000	E/
	Subtotal...	568	760,582,000 (807,463,000)	739	750,138,000	+171	-10,444,000	
47	Quality assurance...	224	5,613,000	224	5,774,000	---	+161,000	F/
49	Patient care and special health services:							
50	(a) Patient care....	5,084	109,914,000	5,084	114,226,000	---	+4,312,000	G/
52	(b) Coast Guard medical services........	151	8,154,000	151	8,344,000	---	+190,000	H/
53	(c) Federal employee health..........	264	5,565,000	264	5,626,000	---	+61,000	I/
54	(d) Payment to Hawaii..........	---	1,200,000	---	1,200,000	---	---	
	Subtotal...	5,499	124,833,000	5,499	129,396,000	---	+4,563,000	
55	Buildings and facilities..........	---	12,000,000	---	5,027,000	---	-6,973,000	J/
	Budget authority..		[14,250,000]		[1,300,000]		[-12,950,000]	
56	Program management..	893	33,177,000	903	35,783,000	+10	+2,606,000	K/
	Total obligations (bases)......	7,184	936,205,000	7,365	926,118,000	+181	-10,087,000	
	Total obligations...		(983,041,000)					

* 1974 Base - Excludes 1973 appropriation restorations. Total obligations shown in parentheses.

Explanation of Changes

A/ Community health centers - The decrease of $5,100,000 is attributed to expected savings due to improved project management.

B/ Maternal and child health - In 1975 project grant authority expires; therefore, all grant funds will be administered on a formula grant basis.

C/ Migrant health - The increase of $250,000 supports the development of special approaches to meet the needs of migrants in low impact areas.

D/ Health maintenance organizations - The net decrease of $5,000,000 includes decreases of $20,000,000 for the loan fund and $2,200,000 in non-recurring technical assistance contracts and increases of $15,000,000 for grants and contracts, $1,784,000 for annualization of 100 positions new in 1974 and $416,000 for 25 new positions in 1975.

E/ National health service corps - The $594,000 reduction is a net decrease of: mandatory increases totalling $249,000; a program increase of $200,000 to support 146 new positions; and a decrease of $1,043,000 for non-recurring contract requirements.

F/ Quality assurance - The increase of $161,000 is for mandatories.

G/ Patient care - The increase of $4,312,000 provides $1,600,000 for health care to the participants in the PHS study of untreated syphilis; $3,989,000 for mandatory increases; and a decrease of $1,277,000 for non-recurring costs.

H/ Coast Guard medical services - The $190,000 is for mandatory increases.

I/ Federal employee health - The increase of $61,000 is for mandatory increases.

J/ Buildings and facilities - The decrease of $6,973,000 reflects the change from non-recurring 1974 funding for PHS hospital modernization to a nominal request of funds for repairs and improvements.

K/ Program management - The increase of $2,606,000 is the net result of the following: (1) program increase of $50,000 to support 10 positions in the National health service corps; (2) program decrease of $832,000 associated with the 53 positions in Maternal and child health which were not restored; (3) mandatory increase for rent payments to the General Services Administration of $4,529,000; (4) built-in decrease of $1,729,000 for project contracts; (5) built-in decrease of $105,000 for equipment and other contractual services; and (6) $693,000 for mandatory increases.

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Total number of permanent positions..................	7,184	7,365	+181
Full-time equivalent of all other positions............	414	416	+2
Average number of all employees..................	7,511	7,631	+120
Personnel compensation:			
Permanent positions........	$94,330,000	$98,437,000	+$4,107,000
Positions other than permanent................	3,082,000	3,064,000	-18,000
Other personnel compensation...................	4,816,000	4,847,000	+31,000
Special personal service payments.................	375,000	375,000	---
Subtotal, personnel compensation...........	102,603,000	106,723,000	+4,120,000
Personnel benefits.........	15,281,000	15,722,000	+441,000
Benefits for former personnel................	218,000	---	-218,000
Travel and transportation of persons..............	4,214,000	4,544,000	+330,000
Transportation of things...	1,633,000	1,649,000	+16,000
Rent, communications and utilities................	3,727,000	8,560,000	+4,833,000
Printing and reproduction..	623,000	643,000	+20,000
Other services.............	33,406,000	29,452,000	-3,954,000
Project contracts........	17,203,000	12,231,000	-4,972,000
Supplies and materials.....	13,011,000	12,208,000	-803,000
Equipment..................	3,181,000	3,131,000	-50,000
Investments and loans......	35,000,000	15,000,000	-20,000,000

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Grants, subsidies and contributions............	753,196,000	716,465,000	-36,731,000
Subtotal.................	983,296,000	926,328,000	-56,968,000
Deduct quarters and subsistence charges (-)..	-210,000	-210,000	---
Total obligations by object..............	983,086,000	926,118,000	-56,968,000
Total obligations excluding 1973 appropriation.....	936,205,000	926,118,000	-10,087,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action Taken or to be Taken
1974 Senate Report	
Migrant Health	
1. The Committee suggestion that the Bureau of Community Health Services take steps to gain experience with issues related to Migrant hospitalization and to develop an appropriate relationship with staff of the Social Security Administration's Medicare program (page 29).	1. During fiscal year 1974 the Bureau of Community Health Services allocated $3,000,000 in migrant health funds for a special project designed to provide hospital care effectively and economically to a selected migrant population and to gather and evaluate data on hospital utilization and cost of hospital services The Bureau of Health Insurance, Social Security Administration, serves as fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Six migrant projects have initiated programs with nine hospitals to provide access to inpatient services at a fixed daily rate for approximately 50,000 migrants.
National Health Service Corps	
2. The Committee suggestion that the Department redouble its efforts to hire the necessary health care staff and place them in the field to serve those citizens living in medically underserved areas (page 30).	2. Through an organized program of visits to medical schools, contacts at professional meetings, letters to prospective members, advertisements in professional journals, exhibits and posters, the Corps has increased its recruitment of physicians and dentists from 14 in 1971 to 335 in fiscal year 1974. As of January 31, 1974 there were 340 health professionals assigned to 183 communities. It is expected that by July 1974 there will be 405 health personnel assigned in approximately 220 communities with critical health manpower shortages.

Item	Action Taken or to be Taken
Family Planning Services	
3. The Committee directs that all family planning activities conform with the "voluntary participation" and "prohibition of abortion" provisions of the Family Planning Services and Population Research Act of 1970 (page 30).	3. Action is continuous to ensure that projects funded under the Family Planning and Population Research Act of 1970 (Title X) comply with the legislative mandate that services must be voluntary and abortions are prohibited. These provisions are addressed in the Title X Regulations published September 15, 1971, as well as in the Title X guidelines currently under development. Furthermore, before a service grant is awarded or refunded, assurance is received by the Regional Office that the project is in compliance with these requirements. Project grant performance measures are currently being developed which will further ensure that these provisions are considered by the Regional Offices when measuring the performance of a grant.
Neighborhood Health Centers	
4. The Committee's approval of management improvement efforts and expectation of increased collections against existing entitlements particularly of Medicare and Medicaid (page 28).	4. A major financial inventory involving 60 neighborhood health centers indicated that collections from all third-party sources were at a level of 13% of total operating costs. With improved fiscal management practices and effective, fair agreements with third-party payors, a collection level of approximately 20% appears feasible. It is expected that all neighborhood health centers will complete the financial inventory process by the end of fiscal year 1974. In addition, implementation of the Health Services Funding Regulations (effective Jan. 1, 1974) will enable projects to recover all available financial reimbursements. These increased collections will allow the projects to serve a greater number of people residing in the target populations.

Authorizing Legislation

Legislation	1975 Authorized	1975 Appropriation requested
Public Health Service Act:		
Title III		
Section 310 -- Migrant Health Grants......	1/	$24,000,000
Section 314(d) -- Grants for Comprehensive Public Health Services..................	1/	90,000,000
Section 314(e) -- Project Grants for Health Services Development.............	1/	200,400,000
Section 329 -- Assignment of Medical and Other Health Personnel to Critical Need Areas..................................	1/	12,383,000
Section 331 -- Lepers.....................	Indefinite	1,200,000
Title X		
Section 1001 -- Family Planning Service Projects................................	1/	94,500,000
Section 1003 -- Family Planning Training Projects................................	1/	3,000,000
Section 1004 -- Family Planning Research..	1/	2,515,000
Section 1005 -- Family Planning Information and Education..........................	1/	600,000
Title XIII		
Section 1309(a) -- Health Maintenance Organizations grants and contracts for feasibility surveys, planning, and initial development.....................	$55,000,000	40,000,000
Section 1309(b) and 1308(e) -- Health Maintenance Organizations Loans and Loan Guarantees for initial operation costs..................................	75,000,000 2/	15,000,000
Social Security Act:		
Title V		
Section 501 -- Maternal and Child Health and Crippled Children's Services........	350,000,000	240,868,000
Section 516 -- Supplemental Allotments....	Indefinite	25,000,000

1/ Authorization expires June 30, 1974; extension legislation is proposed.
2/ Authorization for loan guarantees is indefinite.

Health Services

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1965	$142,536,000	$142,436,000	$143,064,000	$143,064,000
1966	196,616,000	197,480,000	183,480,000	197,980,000
1967	242,521,000	242,271,000	242,271,000	242,271,000
1968	410,599,000	383,406,000	384,209.000	383,806,000
1969	513,476,000	454,847,000	457,847,000	456,347,000
1970	453,507,000	461,297,000	463,207,000	463,207,000
Trust funds transfers	4,320,000	4,320,000	4,320,000	4,320,000
1971	519,798,000	519,798,000	525.940,000	521,248,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1972	648,578,000	652,596,000	693,477,000	664,046,000
Trust fund transfers	4,519,000	4,519,000	4,519,000	4,519,000
1973	694,741,000	739,981,000	833,483,000	739,981,000
Trust fund transfers	5,082,000	5,082,000	5,082,000	5,082,000
1974	817,282,000	817,282,000	860,632,000	838,532,000
Proposed Supplemental	65,000,000			
Proposed transfers for pay raise	2,470,000			
Trust fund transfers	5,299,000	5,299,000	5,299,000	5,299,000
Proposed trust fund transfers for pay raise	314,000			
1975	896,405,000			
Trust fund transfers	5,774,000			

Justification

Health Services

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.......	7,184	$117,892,000	7,365	$122,245,000	+181	+$4,353,000
Other expenses...	---	818,313,000	---	803,873,000	---	-14,440,000
Total..........	7,184	936,205,000	7,365	926,118,000	+181	-10,087,000

General Statement

Funds from this appropriation support the major health service delivery efforts of the Department which are in the Health Services Administration. The concerns of the Health Services Administration are broad, but principally concentrated in five major problem areas or areas of need: reaching underserved populations, correcting inadequate distribution of health services, improving quality of health care, fostering effective and efficient health service delivery, and providing services to statutorily defined populations. Of particular importance in this appropriation is the Health Maintenance Organization initiative begun in fiscal year 1974. This appears to be one of the most promising approaches to improvement of health care organization and delivery in this country.

This appropriation supports a variety of other programs, all of which are designed to improve and/or expand the Nation's health care delivery system. One grouping of programs is organized within the Bureau of Community Health Services. Its fundamental interests have to do with the extension of service capacity in order to resolve problems of access to care. Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers. Comprehensive health formula grants assist the States in planning for and providing health services according to the needs of each State. Maternal and child health formula grants assist the States in providing health services to crippled children and to low-income mothers and their children. Family planning project grants give low-income people an improved opportunity to determine number and spacing of their children. Migrant health project grants serve migrant agricultural workers and seasonal farmworkers and their families with a broad range of health services. The National Health Service Corps provides direct care through the placement of health personnel in areas where health manpower is scarce or non-existent. Major community programs are organizationally identified: Community Health Centers, Family Planning, Health Maintenance Organizations, National Health Service Corps, Migrant Health and Maternal and Child Health -- in order to maintain full accountability to Congressional and Administration action priorities. They are supported by functional groupings of experts and specialists who develop and maintain program guidance and performance criteria, who secure and analyze reports against such standards, and who develop and assist regional personnel in implementing

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*Excludes 1973 appropriation restorations.

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methods and approaches needed to resolve problems which might impede efficient and coordinated program performance.

The Bureau of Quality Assurance provides assistance to the Social Security Administration in establishing, implementing, and evaluating medical care standards under Title XVIII of the Social Security Act (Medicare Program).

The remaining Health Services Administration program supported by this request is the Federal Health Programs Service. Through the patient care and special health services budget activity, the Federal Health Programs Service provides health care to American seamen, personnel and dependents of the Coast Guard and the Public Health Service Commissioned Corps, victims of Hansen's disease, and the participants in the Tuskegee untreated syphilis study.

Among the major items proposed in the 1975 budget is $60,000,000 for the continuation of the Health Maintenance Organizations program, of which $40,000,000 is for grants and contracts, $15,000,000 is for the loan and loan guarantee fund and $5,000,000 is for direct operations. Eighteen health maintenance organizations will become operational in 1975, for a total of 38 by the end of the fiscal year. As provided by Title V of the Social Security Act, authority for maternal and child health project grants terminates June 30, 1974, with a concurrent increase in formula grant authority. The budget requests special financial arrangements to ease the transition to the formula grant program, including $25,000,000 to be awarded under Section 516 of the Social Security Act. The National Health Service Corps budget for 1975 contains a request for an additional 156 positions which will be used to staff 55 additional sites.

Community Health Services

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	568	$8,906,000	739	$10,773,000	+171	+$1,867,000
Other expenses..........	---	751,676,000	---	739,365,000	---	-12,311,000
Total...............	568	760,582,000	739	750,138,000	+171	-10,444,000

Introduction

The Bureau of Community Health Services programs have fundamental interests in the extension of service capacity in order to resolve problems of access to health care. They provide a mechanism for meeting special health needs of people in various regions, for meeting those needs considered to be of national significance and for developing and initially supporting new health services programs. Through a variety of health service funding or support mechanisms the programs foster a comprehensive approach to health care services with special emphasis on reaching underserved segments of the population. As an integral part of the Health Services Administration, the Bureau's activities are coordinated with programs serving statutorily defined populations, the Indian Health Service and the Federal Health Programs Service. Its efforts in maintaining service effectiveness are related to the programs of the Bureau of Quality Assurance.

Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers. The comprehensive health grants to States assist States in establishing and maintaining adequate public health services in accord with their priorities and goals. Maternal and child health formula grants assist States in providing health services to low-income mothers and children and to crippled children. Services provided through the formula grant program are augmented through the maternal and child health research and training programs. Family planning project grants and contracts give low-income people the opportunity to determine the number and spacing of their children. Access to health care services is provided to migrant and seasonal farmworkers and their families through health service project grants located in migrant work areas. The health maintenance organization program provides a mechanism for dealing with specific major problems in health care such as rapid inflation in medical costs, the inadequate emphasis on illness prevention and the increasing unevenness in the distribution and quality of medical care. The national health service corps provides direct health care through the placement of health personnel in areas where health manpower is scarce or non-existent.

The proposed budget includes the consolidation of maternal and child health project grant funds with formula grant funds in 1975, as provided by the 1973 amendments to Title V of the Social Security Act. The following tables outline some of the services provided through the community health services' programs and the budget request for each program:

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*Excludes 1973 appropriation restorations.

Recipients of Community Health Services
(number of persons served)

	1974 Estimate	1975 Estimate
I. Community health centers:		
A. Neighborhood health centers	1,200,000	1,320,000
B. Family health centers	35,000	105,000
II. Maternal and child health services:		
A. Grants to States:		
1. Maternal and child health services:		
(a) Prenatal and postpartum care	501,000	501,000
(b) Family planning services	1,226,000	1,226,000
(c) Well-child conferences	1,500,000	1,500,000
(d) Nursing services	2,700,000	2,700,000
(e) Hospital admissions for comprehensive services	47,000	47,000
(f) Children receiving dental health services	821,000	821,000
2. Crippled children's services:		
(a) Physicians' services	500,000	500,000
(b) Hospital inpatient care	80,000	80,000
III. Family planning services	1,600,000	1,600,000
IV. Migrant health services	355,000	355,000

Community Health Services

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
1. Community health services:						
(a) Community health centers............	---	$205,500,000	---	$200,400,000	---	-$5,100,000
(b) Comprehensive health grants to States..........	63	90,000,000	63	90,000,000	---	---
(c) Maternal and child health:						
(1) Grants to States.........	---	132,678,000	[illegible]	[illegible]	---	+111,273,000
(2) Project grants.	---	111,273,000	---	---	---	-111,273,000
(3) Research and training......	---	21,917,000	---	21,917,000	---	---
(d) Family planning....	---	100,615,000	---	100,615,000	---	---
(e) Migrant health.....	---	23,750,000	---	24,000,000	---	+250,000
(f) Health maintenance organizations.....	100	65,000,000	125	60,000,000	+25	-5,000,000
(g) National health service corps.....	405	9,849,000	551	9,255,000	+146	-594,000
Total.........	568	760,582,000	739	750,138,000	+171	-10,444,000

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*Excludes 1973 appropriation restorations.

Community Health Centers

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses . .	---	$205,500,000	---	$200,400,000	---	-$5,100,000

Introduction

This project grant program is authorized under Section 314(e) of the Public Health Service Act. Its major focus is the support of ambulatory health care programs which provide primary health care and develop arrangements for specialty and inpatient care, particularly in areas where health resources are scarce or non-existent. The flexibility of this authorization has been used to encourage the development of different models for providing a broad range of ambulatory health services which are responsive to the needs of specific population groups. Early in the development of the program, neighborhood health centers became the principal method used to attack maldistribution of health services. Family health centers were developed later as a means of testing whether centers providing a prescribed package of health care benefits to a specifically enrolled population can be designed for, established in, and meet the needs of people residing in health scarcity areas.

Neighborhood Health Centers

During the past two years, a concerted effort has been made to improve the management capabilities of community health centers. The development and installation in the centers of the ambulatory health care information system and the uniform cost accounting system were early initiatives in this effort. All centers, including those newly transferred from OEO, are expected to be meeting reporting requirements by the end of the fiscal year 1974. Thus, project management will have a more valid basis for making decisions concerning allocation of manpower resources and other areas of project operations and effectiveness.

Other efforts supporting overall broad management improvement include internal and external medical audit activities and the institution of various technical assistance programs. As these measures were being developed and put into place, the fiscal management needs of projects became evident, particularly the need for increased third-party reimbursements.

To improve fiscal administration a financial inventory involving team site visits was initiated with the intent of identifying critical financial management issues and of increasing third-party reimbursement levels through improved project administration and management. The financial inventory team reviewed the financial status of 60 HEW centers (with a level of $91,318,114 in 314(e) grant support) and has developed plans with project personnel, for maximizing third-party reimbursements. Where necessary, projects are being provided technical assistance to help them achieve improved financial management. About 40 of the newly transferred OEO centers are expected to complete the financial inventory process by the end of 1974, making a total of 100 centers assisted through central and regional office staff efforts.

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*Excludes 1973 appropriation restorations.

In January 1974, Health Services Funding Regulations were published in the Federal Register making it DHEW policy to encourage health services delivery projects to recover all available financial reimbursements for services they render. Implementation of these regulations will enable projects to use increased collections to serve a greater number of people residing in the target populations.

The management improvement efforts carried out in 1974 and intensified in 1975 will enable us to improve the level of operation of the 118 centers. The 1975 budget requests $5,100,000 less for this activity than was available in 1974. However, we expect this amount to be offset by expected savings resulting from internal project management improvements and will not adversely affect the number of patients served or the quality of services. In fact, based on the increased effectiveness of operations in the centers and collection of third-party funds, a 10 percent increase in the number of patients served is projected for 1975.

	1974	1975
Number of centers	118	118
Target population	4,660,000	4,660,000
Estimated number served	1,200,000	1,320,000

In addition to the direct support of neighborhood health centers, which includes 14 OEO network projects, approximately 40 developmental and supportive projects also receive 314(e) grant support. Network projects are aimed at broad improvements in health care organization within communities and demonstrate improved provider linkages in payment mechanisms. The remaining projects represent a variety of activities generally supportive of health care delivery needs.

Family Health Centers

The family health center effort implements the President's Health Message of 1971 in which he called for services to the underserved, particularly in rural areas. These centers are designed to provide a prescribed package of ambulatory health care benefits to a specifically enrolled population residing in a defined medical scarcity area. There is a basic minimum service benefit package for which the project must have the capacity and capability to deliver or arrange for delivery and which must be available to each enrollee. It consists of emergency ambulance and other medical services; physicians' services (except when provided by a psychiatrist) and services by a pediatric nurse associate or paraphysician; and other medical and health services such as outpatient services, outpatient physical therapy and diagnostic laboratory and x-ray services. In addition, hospital and other non-ambulatory services are arranged for and coordinated by the family health center although grant funds are not used for these services. In a few operational projects some examples of premiums which have been established, thus far, for delivery of the minimum benefit package follow: a New Mexico center, $6.17 per month/member; a North Carolina center, $7.00 per month/member; a Utah center, $7.92 per month/member; and a California center, $9.25 per month/member.

Currently there are 39 family health centers. In 1974, 25 of the centers are operational and the remaining 14 will complete their developmental work. Operational projects have finalized their service benefit packages, developed organizational structures, and initiated enrollment activities. All 25 centers are providing services on either a fee-for-service and/or prepaid basis. The 14 developmental projects, on the other hand, have initiated marketing plans, partially completed cost estimates for their benefit packages, begun limited staffing with at least a medical director, and are developing three-year financial plans. It is estimated that the 25 operational centers will serve approximately 35,000 people in 1974. Several projects are sufficiently developed so that they will be able to convert to the health maintenance organization model.

Comprehensive Health Grants to States

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...............	63	$1,306,000	63	$1,306,000	--	---
Other expenses..............	--	88,694,000	--	88,694,000	--	---
Total.................	63	90,000,000	63	90,000,000	--	---

Introduction

Formula grants awarded to State public health authorities under Section 314(d) of the Public Health Service Act assist the States in establishing and maintaining adequate public health services in accord with priorities and goals established by the States. State health and mental health agencies have utilized these funds to assist in the support of a broad range of basic health programs, projects and activities at the State and local levels. The States are using these funds to support communicable disease control programs such as tuberculosis activities; chronic disease programs directed toward such major causes of death and disability as heart disease, cancer, diabetes and stroke; environmental health services, including food and drug, industrial health, radiological health, sanitary engineering and air and water pollution; laboratory services; home health and public health nursing services; and community mental health, including treatment of alcoholism, drug abuse, and suicide prevention.

Program Accomplishments

The Association of State and Territorial Health Officers (ASTHO) health programs reporting system, funded primarily from the Grants to States for Comprehensive Health Services program, is in its fourth year. This system was designed to elicit uniform data from the State health departments regarding population groups served by specific health programs; total health expenditures by program; anticipated program needs; sources of support; and specific allocation of Federal formula grants, project grants and contracts. Preliminary reports from this system indicate that 314(d) funds support personal health services through State and local health department efforts for at least 7,700,000 people.

Examples of some of the specific uses of 314(d) funds are:

> In Pennsylvania, the tumor clinic and tumor registry program have been used as a means of evaluating treatment of patients with certain types of cancer. The program permits each participating hospital to compare its survival results with results at all other hospitals. Cancer is the only disease for which there is readily available data, in the tumor registry, for evaluating quality of care.
>
> In Delaware, a psychiatric emergency service was established in a rural area of the State by setting up an emergency telephone line, operative 24 hours a day, 365 days a year. Service was manned last year by 20 volunteers.

In American Samoa, filariasis (infestation with worms) is a severe problem and efforts are being made to control the disease through monitoring of overseas travelers and persons arriving from endemic areas.

In Massachusetts, food inspections covered the whole distribution chain from the source of the food to the consumer buying the product. Included in the cycle, for example, were food manufacturers and processors, food trucks, wholesale distribution points and retail food outlets (including stores, restaurants, bakeries and food stands).

The 63 positions are for PHS staff (requested by State health departments) who possess a particular kind of expertise which is essential in State program operations but is often in short supply. Many of these persons are involved in tuberculosis control activities and provide technical advice and management assistance to State and local health department officials in strengthening outpatient services, making case detection efforts more efficient and improving disease prevention activities. Other assignees work in such programs as venereal disease, family planning and epidemiology and perform functions in casefinding, disease prevention and control, data collection and analysis, and related areas.

In 1975, we anticipate that the States will continue to support a broad range of public health programs, maintaining the 1974 service level.

Maternal and Child Health

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses...	---	$265,868,000	---	$265,868,000	---	---
Subactivities:						
(1) Grants to States (Sections 503, 504 and 516)....	---	$132,678,000	---	$243,951,000	---	+$111,273,000
(2) Project grants (Sections 508, 509 and 510)....	---	111,273,000	---	---	---	-111,273,000
(3) Research (Section 512) and training (Section 511).......	---	21,917,000	---	21,917,000	---	---
Total..........	---	265,868,000	---	265,868,000	---	---

Introduction

The basic purposes of the maternal and child health and crippled children's services programs of grants to States are (1) to reduce infant mortality and otherwise promote the health of mothers and children and (2) to locate, diagnose, treat and provide follow-up care for children who are suffering from crippling or handicapping illnesses. In addition to providing grants to States on a formula basis, special projects of regional or national significance are funded which contribute to the improvement, effectiveness and advancement of the programs.

The programs authorized under Title V of the Social Security Act are the major federal resource for providing basic preventive maternal and child health services to persons in economically depressed areas and for the location, diagnosis, treatment, and follow-up care of children with crippling or potentially crippling conditions. They respond to the serious deficiencies that exist in the amount and quality of care received by poor mothers and children which result in an excess of preventable deaths, illnesses and handicapping conditions.

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*Excludes 1973 appropriation restorations.

Under Title V legislation, project grants for maternity and infant care and family planning services (Section 508), comprehensive health care for children and youth (Section 509), and dental health of children (Section 510) will end June 30, 1974, and the funds for such programs will be incorporated into the formula grants to States for maternal and child health services. The legislation stipulates that services provided under project grants in 1974 will continue to be provided to the same population and groups and at the same level in 1975 and future years. The legislation provides for an orderly transition of the project grants into the formula system so that States can coordinate the entire MCH program within their jurisdiction. This requires that each State must have a plan which includes "programs of projects" in the five areas prior to State Plan approval. The projects include maternity and infant care, intensive care of newborns, comprehensive care of children and youth, dental health of children and family planning services. Because project grant funds are not distributed evenly throughout the country the shifting of funds from project to formula grants will result in 22 States receiving less funds in 1975 than 1973. In order to lessen the impact of this and also to "hold harmless" the populations served in fiscal year 1974 by the project grants, $25,000,000 of grant funds will be redistributed under the provisions of Section 516.

Program Accomplishments

Infant Mortality: Significant contributions to recent reductions in the Nation's infant mortality rate have been made through the maternal and child health services program and the maternity and infant care projects. The latter have contributed through their concentration on providing high quality care to low socioeconomic groups who otherwise would have few if any resources for such care. For example, the infant mortality rate in the Baltimore project area has been decreased from 26.8 to 21.9, in Albuquerque from 22.7 to 12.2, in Miami from 23.7 to 2.5 and in Denver from 40.0 to 9.0. Nationwide, these programs have contributed to decreasing the infant mortality rate from 19.8 in 1970 to a provisional rate of 18.5 in 1972, the lowest in our history.

Mental Retardation: The Maternal and child health effort in the prevention of mental retardation through the detection and treatment of phenylketonuria (PKU) and other metabolic disorders has continued. Over 90 percent of the live newborn infants in the Nation are being screened. Accumulating data from this program of early detection and dietary management of affected infants continue to confirm the fact that the program is preventing mental retardation and permitting normal development for the treated infants. Seventeen medical centers are continuing their collaborative efforts to determine when and how the special dietary treatment for these children might be safely discontinued.

The number of supported special clinics offering diagnostic, treatment, management, and counseling services has grown to 166 in the Nation. Over 75,000 mentally retarded children and their families were served by them during the year. The existing 20 genetic counseling services and the 15 specialized services for children with multiple handicaps have likewise, with the adoption of new laboratory techniques and procedures, been able to expand the range and extent of their services.

Nutrition Services: As an integral part of the maternal and child health and crippled children's programs, nutrition services are provided through well-child clinics, pediatric clinics, group care facilities and school health programs. Progress in offering more adequate nutritional services to women during pregnancy and in preventing iron-deficiency anemia in children were two of the significant accomplishments reported during 1973. Currently about 1,000 nutrition personnel are supported by State and local health agencies through Title V grants.

(1) Grants to States

(a) Maternal and child health services: States use Federal funds, together with State and local funds, for prenatal delivery, and postpartum care in rural areas. Mothers may receive clinical services including family planning services, home visits by public health nurses, and pediatric and well-child clinics where mothers can bring children for examination, immunization, and competent advice are made available. Such measures have been instrumental in the reduction of maternal and infant mortality. Funds are also used to provide medical, dental and nursing services for school health examinations and immunizations in rural areas.

The 1975 estimate will support the consolidation of project grant with formula grant funds. As noted earlier, the maternal and child health plan in each State must include programs of projects that provide the services formerly provided under project grant authority. Following is a brief description of the kinds of projects supported in 1974.

(i) Maternity and infant care: This program, begun in the spring of 1964, now has 61 projects in operation in large and middle-sized cities and in rural areas. The projects are located in 34 States, the District of Columbia and Puerto Rico. Each was established to serve a locality which in the past showed much higher infant and maternal mortality rates than the Nation as a whole. It is estimated that by the end of 1973 slightly more than a million women had been admitted to the projects for maternity services.

(ii) Intensive Care projects for high-risk infants: This program was begun in 1970 with five projects providing specialized care for infants born at high risk (prematurely born or with other conditions detrimental to their normal growth and development). Studies in this and other countries have shown that a considerable degree of effectiveness in reducing the mortality rate among high-risk infants can be achieved through the use of special intensive care units or centers. These provide increased medical and nursing supervision, care by personnel specially trained in such fields as treatment of cardiopulmonary failure and respiratory distress in newborns, the use of special equipment as needed and organization of transportation services. Eight intensive care projects are being supported in 1974.

(iii) Comprehensive health care for children and youth: The "Children and Youth" project grants support comprehensive health care for children in areas where low-income families are concentrated. Projects provide screening, diagnosis, preventive services, correction of defects and after-care (both medical and dental). Services are coordinated with the programs of the State or local health, welfare and education departments and related programs in HSA. The treatment services available under the program are provided only to children from poor families who would not otherwise receive such care. Diagnosis, preventive services and health supervision are available to all applicants. Since the last quarter of 1968, the number of registrants in the children and youth projects has more than doubled to 483,000. In 1974, 62 projects were in operation in 28 States, the District of Columbia, the Virgin Islands and Puerto Rico. Each serves a specific low-income area. Two-thirds of the projects and nearly 90 percent of the children enrolled live in the inner cities. A breakdown of registrants shows that 64 percent are black, 32 percent white and 4 percent are of other races. The average annual cost per child has dropped from $201 in 1968 to $130 in 1973. There has also been a consistent decrease in illnesses requiring hospital inpatient care and the average length of stay has decreased from 10 days to 7 days.

(iv) Dental health of children: This program was initiated in 1971 and provides dental care through a variety of approaches including incremental care programs which emphasize prevention and continuing dental supervision. These projects augment the dental care which has been available through the State maternal and child health and crippled children's programs and the Children and Youth and Maternity and Infant Care projects. Eighteen projects are being funded in 1974 providing dental care to 21,000 children.

(v) Family planning services: Services provided under Title V funds include comprehensive family planning medical, educational, and social services. These services include physical examinations, preparation of the patient's medical history, various laboratory tests such as blood pressure, urinalysis, the provision of contraceptive supplies and referral for other health needs. In 1974, it is estimated that 300,000 women are being provided such services through these projects.

The following outlines some of the more significant services being provided or to be provided through the maternal and child health formula and project grant program:

	1974 Estimate	1975 Estimate
Mothers receiving prenatal and postpartum care in maternity clinics	501,000	501,000
Infants admitted for comprehensive services	47,000	47,000
Women receiving:		
Family planning services	1,226,000	1,226,000
Maternity nursing services	2,700,000	2,700,000

	1974 Estimate	1975 Estimate
Children attending well-child clinics........	1,500,000	1,500,000
Children registered for comprehensive services..................................	483,000	483,000
Children receiving dental treatment..........	821,000	821,000
Children screened:		
Visual screening..........................	9,000,000	9,000,000
Audiometer testing........................	6,000,000	6,000,000
Dental screening..........................	3,000,000	3,000,000
Immunizations (excludes booster and revaccinations):		
Polio..................................	2,750,000	2,750,000
Rubella................................	3,000,000	3,000,000
Diphtheria.............................	3,000,000	3,000,000

During 1975 professional and technical assistance will be provided to States in the development of new projects to meet the programs of projects' requirement.

1975 Program: The allotment of 90 percent of the appropriation by formula in 1975 and each year thereafter will result in significant changes in the States' maternal and child health programs. Whereas at present, 36 jurisdictions have maternity and infant care projects, beginning in 1975 all States will be required by statute to have a program of maternity and infant care projects. Similarly, all States will have children and youth projects, whereas at present 31 States have such projects. Each State program must also include dental care projects, neonatal intensive care projects, and family planning projects. The following table illustrates the number of new projects required in each project area:

Project Area	1974 Jurisdictions with projects	Total required in 1975	New projects required by law
Maternity and infant care...	36	56	20
Intensive care of newborns....................	8	56	48
Children and youth..........	31	56	25
Dental care.................	16	56	40
Family planning.............	27	56	29
Total.....................	118	280	162

(b) Crippled children's services: Grants to States for crippled children are used by agencies to locate handicapped children, to provide diagnostic services, and then to see that each child gets the medical care, hospitalization, and continuing care by a variety of professional people. Fewer than half of the children served have orthopedic handicaps.

Other handicaps include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, heart disease, and other congenital defects. Clinics are held periodically by State crippled children's agencies. Some clinics are mobile and travel from place to place; others are held in permanent locations. Any parent may take his child to a crippled children's clinic for diagnosis. Within the last two decades the caseload in the crippled children's program has more than doubled.

The following outlines some of the specific services provided through this program:

	1974 Estimate	1975 Estimate
Children receiving physicians' services.......	500,000	500,000
Children receiving hospital inpatient care,...	80,000	80,000

1975 Program: It is expected that services will be provided in 1975 at approximately the same level as in 1974.

(2) Research and training

The training program (Section 511) is designed to improve health and medical services to mothers and children through training of personnel involved in providing health care and related services to mothers and children, particularly mentally retarded and multiple handicapped children.

The funds requested will be used principally to support the existing 20 university-affiliated centers for the mentally retarded where primary effort has been given to training service providers. Grants to public or nonprofit institutions of higher learning provide support for faculty, traineeships, services, clinical facilities and short-term institutes and workshops. These centers provide specialized clinical training in a multidisciplinary setting for physicians and other maternal and child health personnel who focus their activity on the multiple handicapped child. Emphasis in the centers is on the provision of excellent quality health care conducted in a training setting.

In 1972, with an increase of funds under Section 511 of the Social Security Act a new program was initiated to train obstetrical and pediatric health manpower. In 1974, it is estimated that 150 health personnel will receive training as nurse midwives, pediatric nurses, and other physicians' assistants under this program with funds provided to 15 insitutions. Of the $15,882,000 requested in 1975, $14,382,000 will support the existing 20 university-affiliated centers for training personnel to provide services to the mentally retarded and $1,500,000 will be used to continue the nurse and other physicians' assistants training programs.

Research grants are made with public or other nonprofit institutions of higher learning and public or nonprofit private agencies. The research effort is concerned with mothers and children in all classes of our society with priority given to special problems for those not receiving adequate health care. The aim of the research program is to improve the operation, functioning, general usefulness and effectiveness of maternal and child health and crippled children's services. Research efforts are primarily intended to improve program implementation and management, with emphasis on efficiency and effectiveness of the actual operating service delivery mechanisms. The research program through its 68 projects is focusing on improving health and medical services to mothers and children. In keeping with the mission of the research program, projects emphasize maximum usability of end results. An ongoing project in the area of design and development of new prosthetic devices for child amputees is designed to enhance the ability of health personnel working with crippled children to respond more effectively to the needs of their patients. The project also incorporates study of the needs and problems of child amputees, and currently is preparing a new manuscript for a textbook on the treatment of the limb deficient child.

Another ongoing project of great significance is designed to develop methods of treating infants born to drug addicted mothers. In 1974 special emphasis is being given to the need for, and feasibility and effectiveness of comprehensive health care programs in which maximum use is made of health personnel with varying health levels of training.

The 1975 request of $6,035,000 would continue support of 68 research projects in the broad field of maternal and child health and crippled children's services.

Family Planning

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses...	---	$100,615,000	---	$100,615,000	---	---
Subactivities:						
(1) Family planning services...	---	$94,500,000	---	$94,500,000	---	---
(2) Training and education..	---	3,600,000	---	3,600,000	---	---
(3) Services delivery improvement.	---	2,515,000	---	2,515,000	---	---
Total	---	100,615,000	---	100,615,000	---	---

Introduction

Family planning services are designed to provide educational, comprehensive medical and social services to enable individuals to determine freely the number and spacing of their children. The lack of family planning services and related education and information causes unwanted pregnancies which result in numerous health, social and economic problems, and deprives individuals of the right to control their own fertility.

The major responsibility for delivery of family planning services rests with the Bureau of Community Health Services, HSA, which administers a program of project grants and contracts for the support of clinics, training of allied and other health personnel, development and distribution of family planning educational materials, and operational research and technical assistance to improve the delivery of family planning services.

Family planning services: Family planning project grants are authorized by Title X of the Public Health Service Act. The purpose of these grants is to provide comprehensive family planning services to thousands of individuals who, for many reasons, are denied access to these services. Grants are awarded to State and local health agencies, hospitals, universities, community agencies and other public or nonprofit groups. Services include comprehensive family planning medical, educational, and social services. Physical examination, preparation of a patient's medical history, various laboratory tests such as blood pressure and urinalysis, provision of contraceptive supplies, and services for detection, diagnosis and referral are among the specific services provided. Other services include patient counseling and education, social services and information necessary for the individual to rationally decide which contraceptive method, if any, is most suitable to his or her needs.

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*Excludes 1973 appropriation restorations.

Family planning services are being provided in areas with high rates of maternal and infant sickness and death. Continuing efforts are being made to integrate family planning projects within existing health systems. Many projects presently supplement programs of State and local health departments or other Federal programs to avoid duplication of effort. Organized programs for the delivery of family planning services currently exist in 2,379 of 3,099 counties in the United States.

During 1974, the complete transfer of the remaining 187 OEO family planning projects will be completed. These projects will be consolidated with ongoing family planning projects wherever possible, reducing the total number of family planning projects from about 500 to 350 by the end of 1974. In 1975 continuing emphasis will be placed upon grant consolidation in order to lower unit costs. Service delivery levels, of course, will be maintained.

A variety of approaches will be taken to improve project administration. Project accounting systems will be generally upgraded. Efforts will be focused on the collection of available reimbursements, particularly those authorized under Title IV-A and XIX of the Social Security Act. In this regard, special attention is being given to national level coordination with the Medical Services Administration and other Department organizations in the resolution of administrative practices which inhibit full reimbursement.

Training: The objective of family planning training activities is to promote the skills and knowledge necessary to insure that all family planning staff will have the skills necessary to successfully provide voluntary family planning services. Twenty training grants and contracts totalling $3,000,000 will be awarded in 1975. These will provide for the development of management skills for key personnel; the training of service delivery staff; and development of training guides, audiovisual aides, self-instruction courses, and related materials. Approximately 5,000 personnel involved in the delivery of family planning services will receive training. Included are physicians, nurses, social workers, outreach workers, administrators, office and clinic personnel and consumer board members. The 1975 training strategy will be to support efforts to provide technical assistance and consultation to regional, State and local activities to assist in the building of training sufficiency at the project site.

Education: Efforts include those activities required to ensure that individuals have a full and accurate understanding of how to safely and effectively regulate their fertility. The major objective is to give direct support to service projects in the development of provider and patient-oriented information and education programs and to extend and improve the understanding, knowledge and commitment of the total community to the potential benefits of effective family planning services. In 1974, five contracts totalling $600,000 were supported. Prototype family planning and health education materials were developed for members of specific ethnic and cultural minorities--the American Indian and Spanish-speaking Americans. Workshops were supported to identify the family planning and family life education needs of the mentally retarded and to provide technical assistance and skills development in the area of information and education to service providers. The 1975 program will bring together State leaders and parents to discuss current activities and strategies for developing family planning and family life education for the mentally retarded within their State and to assess the information and material derived from the four workshop meetings held in 1974.

Services delivery improvement: Special studies and programs are supported to develop and improve the ability to mount a coordinated program responsive to family planning priorities, to significant regional, State and local variations and to special target groups. This represents an attempt to coordinate program needs and resources into a manageable strategy for searching, developing and testing the most efficient and effective methods and techniques for the delivery of family planning services. These operational research projects are in the areas of experimental and demonstration projects, technical assistance and management information support.

In 1974, five contracts were awarded for the design, development and testing of methodology and instrumentation for management information and one for the development of a prototype planning tool. Other special studies included the design and development of an experimental operations model to support family planning program management and the development of definition and design for consumer models and materials for family planning management training. In 1975, demonstration projects such as specialized information and referral activities in rural areas will be developed or tested in order to facilitate the delivery of Family Planning Services to the hard-to-reach, the disabled and the dropout. A prototype model for third-party reimbursement on a statewide level will also be tested.

In 1975, the training curriculum and delivery techniques for natural family planning methods will be investigated. The purpose is to upgrade the capability of Federally-funded family planning clinics to enable them to instruct patients who choose the rhythm family planning method in keeping with individuals' ethical or religious beliefs.

Management support will be provided to the New England States by the development of an expanded automated system which will also be generated for third-party billing. The system may also serve as a prototype for family planning local-level management as it utilizes the standard form of and provides input to the National Reporting System for Family Planning Services.

A primary planning effort in 1974 and 1975 will be the Fourth Update of the National Five-Year Plan for Family Planning Services Programs required by Congress in January 1975. In 1974 and 1975, family planning activities will also continue financial support to the National Reporting System for Family Planning Services which will satisfy program requirements as well as Departmental responsibilities as the focal point for family planning services.

Migrant Health

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses...	---	$23,750,000	---	$24,000,000	---	+$250,000

Introduction

Projects supported under this activity provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. These projects are authorized by Section 310 of the Public Health Service Act. Services provided range from a full grouping of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, health counseling, preventive and outreach services to a more limited focus on specific diseases.

The number of projects and people served follows:

	1974	1975
Number of projects...........	103	103
Estimated number of patients served............	355,000	355,000
Estimated number of patient visits.............	630,000	630,000

Migrant health projects will continue to increase access to quality health care services for migrant and seasonal farmworkers and their families.

In line with the overall strategy decided upon with respect to the Bureau of Community Health Services' third-party reimbursement activities, 13 of the largest migrant projects have had a financial inventory carried out by a team of experts who identified specific fiscal management problems and helped project officials devise special plans for the resolution of those problems. Smaller projects will be assisted through such activities as the uniform utilization and cost reporting system which is being implemented in 1974 and has the potential to provide projects with the kind of data needed to aid them with financial management, evaluation, planning, and other aspects of administration.

A special project, designed to provide hospital care effectively and economically for a selected migrant population and to gather and evaluate data on hospital utilization and cost of hospital services, was initiated in 1974 at a level of $3,000,000. The Bureau of Health Insurance, SSA, serves as the fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Six migrant health projects have initiated programs with nine hospitals to provide access for approximately 50,000 migrants to inpatient services at a fixed daily rate. In addition to providing needed hospital services, information necessary for program planning and resource allocation concerning the hospitalization needs of migrants will be available. This information includes: frequency of hospital use by age, sex, diagnosis and other variables; analysis of hospital services used; detailed analysis of the total and component cost of hospital care; study of pre- and post-hospitalization use of ambulatory care services; comparative analysis of migrant hospitalization experience with experience of other low-income groups; and an overall summary and analysis of the demonstration program.

Another activity in 1973 and 1974 involved a survey and analysis to determine the nature of sanitary conditions at selected migrant camps. This survey was prompted by the outbreak of typhoid fever in a south Florida migrant camp last year. Findings from 29 randomly-selected camps in the survey indicated that 13% of the camps dumped sewage directly into open streams; in 22% of the camps no water sample had been taken, thus there was no assurance of the safety of the water; and while only 14% of the camps used privies, 26% of the toilet facilities were judged dirty and foul-smelling, and 35% provided no toilet paper. The overall results of the survey indicated that a much more vigorous program of camp inspection and enforcement of the existing regulations of the States having camps is needed.

During 1975, active coordination efforts with Labor Department officials responsible for occupational health and safety will be emphasized in order to accomplish corrective measures in this needed area. Using the $250,000 increase, special efforts to build on existing health service delivery resources will be made to ensure that more migrants working in low-impact areas (less than 6,000 migrants) will have access to services as they move from home base and other high-impact counties to areas which are either unserved or provide only minimal project services.

Health Maintenance Organizations

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...........	100	$483,000	125	$2,101,000	+25	+$1,618,000
Other expenses..........	---	64,517,000	---	57,899,000	---	-6,618,000
Total.................	100	65,000,000	125	60,000,000	+25	-5,000,000[1]
Subactivities:						
(1) Financial assistance grants and contracts.......	---	$25,000,000	---	$40,000,000	---	+$15,000,000
(2) Direct loan and loan guarantee fund...........	---	35,000,000	---	15,000,000	---	-20,000,000[1]
(3) Program support.........	100	5,000,000	125	5,000,000	+25	---
Total.............	100	65,000,000	125	60,000,000	+25	-5,000,000[1]

Introduction

Health Maintenance Organizations (HMOs) provide comprehensive health services on a prepaid, capitation basis with emphasis on primary care, preventive services, and efficiency of operations. The recently enacted Health Maintenance Organization Act (P.L. 93-222) provides for:

1. grants and contracts for feasibility surveys;
2. grants, contracts, and loan guarantees for planning and for initial development costs;
3. loans and loan guarantees to cover initial operations deficits for the first three years of operations.

Priority for all types of assistance is to be given to HMOs serving rural and other medically-underserved populations. Assistance to profit-making HMOs is limited to loan guarantees for those which will serve such populations. Public and private nonprofit HMOs are eligible for the other forms of assistance.

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[1] The loan fund is a revolving fund; therefore, a decrease in appropriation level does not reflect a decrease in program level.

Each HMO is required to make available to each member certain prescribed basic health services, in a manner assuring continuity of care. HMOs receiving assistance must provide assurances of compliance with provisions of the legislation with respect to organization and operations.

Section 1310 of the HMO Act requires employers of 25 or more persons who offer health benefits plans to include the choice of membership in a qualified HMO, if one is available, to their employees ("dual-choice"). "Qualified" HMOs must be certified by the Secretary as meeting the requirements of the HMO Act and of the regulations pursuant to the Act. Such HMOs, as well as those which have received assistance under the Act, are subject to continued regulation by the Department. Civil suits may be brought against organizations which fail to comply with the assurances made when applying for certification under Section 1310 or for financial assistance.

An appropriation of $60,000,000 is requested for the HMO program in fiscal year 1975. The following table shows the estimated distribution of 1974 and 1975 funds and the number of projects to be funded in each category of financial assistance:

HMO Activity	1974		1975	
	No.	Amount	No.	Amount
Feasibility studies	60	$3,000,000	60	$3,000,000
Planning	48	6,000,000	48	6,000,000
Initial development	20	16,000,000	39	31,000,000
Loans	20	35,000,000	38	15,000,000
Program support	--	5,000,000	--	5,000,000
Total	148	65,000,000	185	60,000,000

Financial Assistance Grants and Contracts

Feasibility Assistance (Section 1303): This request includes an estimated $3,000,000 for approximately 60 organizations in 1975 to enable them to determine, through surveys and other activities, whether it is feasible to develop or expand an HMO. Grants and contracts for feasibility assistance are limited to $50,000 per award. It is estimated that close to 75% of those organizations given assistance will determine that it appears feasible to develop an HMO and will subsequently move on to the planning phase.

Planning and Initial Development (Section 1304): Funds totalling $6,000,000 are requested to provide grant or contract support in 1975 for approximately 48 planning projects, at a maximum of $125,000 per award. In addition, $31,000,000 is requested for about 39 projects in the initial development stage, at a maximum of $1,000,000 and an average of $800,000 each. Loan guarantees will be available to profit-making HMOs for these activities. Planning projects are required to include the development of plans for marketing the services of the HMO. Initial development assistance will help support (1) implementation of an enrollment campaign, (2) design of and arrangement for health services, (3) development of administrative and internal organizational arrangements, including development of capital financing, (4) recruitment and training of personnel, and (5) payment of architects' and engineers' fees. Initial development is defined to include the significant expansion of the membership of, or the areas served by, an HMO.

The amount of money needed to support an HMO in its planning and initial development stages will depend on the structure and sophistication of the organization. Some (such as established multi-specialty group practices) may require relatively small amounts of support to convert to HMOs. For others, the planning, development, capital, and operating costs will probably be higher. It is estimated, for example, that a hospital-based group practice that develops into an HMO may need 20,000 to 30,000 enrollees before it reaches the break-even point. This is a formidable marketing challenge, requiring substantial funds for initial development.

Direct Loan and Loan Guarantee Fund

Loans for public or nonprofit private HMOs and loan guarantees for profit-making HMOs serving medically underserved populations are authorized under Section 1305; such loans and loan guarantees may not exceed $1,000,000 in any fiscal year and $2,500,000 total for the first three years of operation.

In order to implement the loan program, $15,000,000 is included in this request, in addition to $35,000,000 requested as a supplemental appropriation for 1974, to provide capitalization of the direct loan and loan guarantee revolving fund. An estimated 38 HMOs will receive direct loans from the fund in 1975, at an average of about $500,000 per year. This represents an increase of 18 new HMOs over the 1974 level; the 20 initially funded in 1974 will be continued in 1975. Using the assumption of 25,000 enrollees per HMO (which is applicable primarily to hospital-based HMOs) the 38 new HMOs would have an eventual capacity to serve approximately 1,000,000 people. Loan guarantees will also be available for planning and initial development.

The fund will be replenished by sale of the loans. Once sold, the loans become loan guarantees for which the Federal government guarantees the payment of principal and interest to the purchaser of the loan. The fund will be used to make any necessary assumption of payments or cover any defaults. Section 1308 authorizes the Secretary to borrow from the Treasury if funds in the loan guarantee fund are insufficient to cover defaults.

Program Support

For fiscal year 1975, $5,000,000 and 125 positions are requested for program support. The request includes 25 new positions of which the majority will be allocated to the Regional Offices to expand the administration of the financial assistance programs and to provide monitoring of certified HMOs and employers for compliance with Title XIII. Regional Office staff will assume an increasingly important role as a focus for coordinated activity at the regional level through monitoring of assisted and certified HMOs. Coordination with other Federal agencies, States, and organizations in the private sector will continue. Support services will continue to be provided in the areas of technical assistance to developing HMOs, medical care administration, grant and contract management, health care financing, data services, administrative and financial management, and policy development.

Support will be provided to HMOs, both directly and through contracts, in critical areas of their operations. These include medical records (as a key factor in quality assurance and compliance with reporting requirements); accounting and financial management systems (particularly with regard to assurance of fiscal viability after termination of Federal financial assistance); actuarial assistance to help HMOs develop capitation rates; consumer education; and marketing of the benefit program.

Initial implementation of the HMO Act in 1974 will require the development of policies, regulations and guidelines, definition of operating relationships and methods of operation, recruitment and training of staff, and establishment of effective working relationships with other Federal agencies for the purpose of beginning the certification of qualified HMOs eligible for the dual-choice provisions of Title XIII, as well as with agencies responsible for the purchase of health care for their beneficiaries.

National Health Service Corps

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	405	$7,117,000	551	$7,366,000	+146	+$249,000
Other expenses............	---	2,732,000	---	1,889,000	---	-843,000
Total..................	405	9,849,000	551	9,255,000	+146	-594,000

The National Health Service Corps was established in 1971 to improve the delivery of health services to persons living in communities and areas of the United States where health personnel and services are inadequate to meet their health needs. To alleviate the critical health manpower shortage, the Corps recruits and places health teams consisting of physicians, dentists, nurses, and allied health professionals in shortage areas. The Corps seeks to improve health services in communities not only by providing temporary help but principally, by helping these areas plan and build their own systems of health care.

Corps personnel help communities apply for assistance from the program. The application must include certification of need from State and local health societies and recommendations from other health agencies. The applicant community is required to arrange for adequate facilities, equipment, hospital privileges, and consulting arrangements.

The Corps has emphasized the development of an effective long-term recruitment program for provider personnel, especially physicians. Through an organized campaign of visits to medical schools, contacts at professional meetings, letters to prospective members, advertisements in professional journals, exhibits and posters, the Corps has increased its recruitment of physicians and dentists from 14 in 1971 to 335 in 1974.

A major activity has been the provision of assistance to community groups in setting up programs that link assignees to other provider units. These programs greatly improve the possibility of the health provider's remaining in the community. The Corps' retention rate for 1974 will be 25% compared to 3% in 1973.

The assignee's and the community's needs and preferences are evaluated to mesh community and individual priorities as closely as possible. This interchange of information minimizes the possibility of future dissatisfaction of either party.

Since its beginning, the Corps has approved 307 sites for Corps assistance and has placed 340 doctors, dentists, nurses and other health professionals in 183 communities. It has experimented successfully with utilizing physician extenders (nurse practitioners and physicians' assistants) to provide health services. The presence of Corps personnel has drawn other health professionals to areas which were medically underserved.

By the end of 1974, staff will have been recruited and matched to the needs of approximately 220 communities. During the first quarter of 1975 all staff will have reported on duty and begun service in these communities. This budget request will support recruitment of an additional 146 health personnel for field assignments, which would provide health care to approximately 55 additional communities and continue the support of 405 health professionals in approximately 220 communities with critical health manpower shortages.

	1974 Estimate	1975 Estimate
Field assignments:		
MD	264	358
DDS	71	94
RN, Others	70	99
Total	405	551
Communities	220	275

Quality Assurance

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..........	224	$4,241,000	224	$4,402,000	---	+$161,000
Other expenses..........	---	1,372,000	---	1,372,000	---	---
Total..............	224	5,613,000	224	5,774,000	---	+161,000

The Bureau of Quality Assurance in partnership with the Social Security Administration's Bureau of Health Insurance (BHI) supplies the professional health expertise necessary for carrying out the Federal government's responsibility for establishing, implementing, and evaluating Medicare standards and related policies. Review, assessment, and updating of all Medicare requirements for providers of service and independent laboratories were completed in 1973. Professional staff worked closely with Medicare and Medicaid program staff, and final regulations for Skilled Nursing Home Facilities were published in the Federal Register in January 1974. Uniform certification procedures for these facilities were also published as Medicare and Medicaid regulations and will serve, effective February 1974, as the base for participation under both financing programs. In 1975, at both central and regional level, staff will continue to orient State agencies with respect to the new standards and regulations for skilled nursing facilities and other providers of service, and will carry out various monitoring and validating activities in relationship to the application of the standards.

To help ensure effective application of Medicare quality standards, physicians, nurses, and other health services specialists assigned to regional offices provide continuing assistance and consultation to State Medicare agencies and regional Social Security staff. The resulting improvement of facilities and services has benefited persons of all ages, has strengthened State licensure statutes and regulations for health facilities, has had a positive effect on voluntary accrediting programs, and will provide the base for assurance of quality care in any national health insurance program the Congress may enact.

In 1974, substantial staff assistance was given to the Social and Rehabilitation Service in the enforcement of the Medicaid requirements for skilled nursing homes. Regional personnel assisted with monitoring State agency performance, conducted facility surveys, and otherwise assisted SRS in achieving its goal of initiating an ongoing survey and certification program for all participating skilled nursing homes. In 1975, both headquarters and regional personnel will provide direct assistance and advice to the Social and Rehabilitation Service on the implementation of regulations for skilled nursing facilities, intermediate care facilities, utilization review, and medical review under the Title XIX (Medicaid) program.

Program review has become a major continuing process for evaluating the effectiveness of the application of the Medicare provider standards by State agencies. During 1974 and 1975, review teams composed of representatives of the Bureau of Health Insurance and the Bureau of Quality Assurance central and regional offices will conduct, on a selective basis, reviews in various States, and provide in-depth evaluations of each State's Medicare certification operations. Each State will be evaluated during the period July 1, 1973 - June 30, 1975. Year-round evaluation of State agencies as determined by regional office staff will be enhanced through quarterly visits and sample surveys of providers in each of the State agencies served by the regional office.

In addition, with the implementation of a single set of Medicare and Medicaid standards and common enforcement policies for skilled nursing facilities and intermediate care facilities, efforts are underway to put into effect a program review process which will monitor the survey and certification functions at the State level for both programs.

Training efforts for State survey personnel will continue in 1975 to encompass a more integrated and complete program. Special attention will continue to be given to standardized orientation for Federal and State employees, regional office orientation, advanced survey and consultation techniques, and supervisory development. Programmed instruction will be utilized where applicable.

Consultation is provided to the Social Security Administration on a continuous basis on questions concerning covered services under Medicare, professional ethics, termination of provider status, emergency hospital claims, chiropractic and other practitioners' services, and the development of policy and procedures not related specifically to standards for providers or suppliers, which have an impact on quality or delivery of service.

The Social Security Amendments of 1972, P.L. 92-603, require the Secretary to provide a route to qualification, other than formal education requirements, for a variety of health disciplines. In 1973, staff initiated a number of activities related to this: (1) review of related programs, both governmental and otherwise, from which the Medicare program could benefit; (2) development of intra-government agreements for use of existing examinations; and (3) contracting for the development and administration of proficiency examinations which would qualify specified health care personnel. Such examinations will apply to waivered licensed practical nurses, cytotechnologists and clinical laboratory technologists not meeting Medicare's formal professional qualifications, physical therapists, radiologic technicians and psychiatric technicians. In FY 1975 an evaluation program will be designed to measure the effectiveness of this proficiency examination program.

Another major responsibility, under P.L. 92-603 (Section 299I), is the end-stage renal disease program. Planning and development of interim regulations occurred in 1974. The planning for the statutory requirements for establishing medical review boards will begin in 1974. Also, planning for a national patient transplant and dialysis outcome registry will be conducted in 1974. In 1975, the implementation for these stages of the regulations will be conducted. Development of the conditions of participation for the long-range program will begin in 1974 and be completed in 1975.

A total of $5,774,000 is requested for this activity. The increase of $161,000 over the 1974 level of operations is requested to cover mandatory items. This program is funded in its entirety by reimbursement of funds to this appropriation from the Social Security Trust Funds.

Patient Care and Special Health Services

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.........	5,499	$85,579,000	5,499	$88,245,000	---	+$2,666,000
Other expenses.........	---	39,254,000	---	41,151,000	---	+1,897,000
Total.............	5,499	124,833,000	5,499	129,396,000	---	+4,563,000
Reimbursable obligations.		-20,165,000		-20,212,000		-47,000
Direct obligations.......		104,668,000		109,184,000		+4,516,000

Introduction

This program provides direct and contract health care to the 500,000 legal beneficiaries of the Public Health Service. Major beneficiary groups are American seamen, personnel and dependents of the Coast Guard and the Public Health Service Commissioned Corps, Federal employees' compensation cases and persons with Hansen's disease. Health care is provided for participants and certain spouses and children of participants in the Public Health Service study of untreated syphilis initiated in 1932. On a reimbursable basis, care is provided in PHS hospitals and outpatient clinics to foreign seamen and beneficiaries of other Federal agencies, and to Federal employees in Federal employee health units.

Patient Care

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..	5,084	$78,643,000	5,084	$81,191,000	---	+$2,548,000
Other expenses.......	---	31,271,000	---	33,035,000	---	+1,764,000
Total.............	5,084	109,914,000	5,084	114,226,000	---	+4,312,000
Reimbursable obligations..............		-15,165,000		-15,165,000		---
Direct obligations...		94,749,000		99,061,000		+4,312,000

Mission

The primary mission of this program is to provide comprehensive health care to Public Health Service beneficiaries. On a reimbursable basis, health care is also provided in PHS hospitals and outpatient clinics to foreign seamen and beneficiaries of other Federal agencies.

The program operates eight general medical and surgical hospitals, most with teaching and research programs, and the National Leprosarium at Carville, Louisiana. In addition, the system operates 26 outpatient clinics and contracts with about 200 physicians and dentists to provide health care to ambulatory patients. When PHS facilities are not readily accessible, beneficiaries receive care in other Federal and non-Federal facilities.

Future Plans

In 1975, this program will continue to operate the PHS hospitals and outpatient clinics in accord with Public Law 93-155, which provides that the PHS hospitals continue to furnish all patient care services unless Congress agrees to a planned change. In view of this legislation, the Department has established a task force within the Public Health Service to define the position and roles of the PHS general hospitals and their relationships with other HEW programs. It is expected that the task force will find ways in which the hospitals can be better utilized to the benefit of this program, as well as to programs of those health agencies and communities which may utilize the capabilities of the PHS hospitals. For example, there appear to be good opportunities for PHS facilities to participate in such programs as the National Health Service Corps. In addition, the hospitals' existing levels of participation in community programs involving renal dialysis, alcoholism treatment, family planning, and community mental health can most probably be expanded; at the same time the program would be taking initiatives in new kinds of community health programs.

Estimated patient care workloads for 1974 and 1975 are as follows:

Workload	1974	1975	Change
Average daily patient load (ADPL) in PHS hospitals	1,520	1,778	+258
Outpatient visits to:			
PHS hospitals	745,000	792,000	+47,000
PHS outpatient clinics	725,000	765,000	+40,000
Contract care:			
ADPL in non-PHS hospitals	99	89	-10
Visits to contract physicians	68,000	64,000	-4,000

Research

Research activities currently conducted in PHS hospitals include both clinical and health services research. Clinical research activities are concerned primarily with major disease problems of the United States, such as cardiovascular disease, cancer, and chronic kidney disease. Health Services research projects are directed to the need to improve the quality, efficiency, and economy of the delivery of health services.

The PHS hospitals have the capacity to broaden research activities, especially where these projects can be funded by other agencies. Currently, the bulk of the research is being funded by agencies such as the National Institutes of Health. A more varied and expanded research program in turn will aid recruitment and retention of health professionals. The task force will be considering new areas for utilizing the hospital capabilities.

Training

Part of the overall strategy for efficient utilization of PHS facilities is strengthening present training programs and developing new ones. The additional manpower trained and the upgraded performance of existing personnel would help overcome the recent manpower shortages in the hospitals and clinics.

Presently in training are 146 medical residents and 57 medical interns. Dental training includes eight residents and 35 interns. Thirty-five physician assistants are being trained for patient care employment in the hospitals and clinics. Affiliations with universities and colleges provide paramedical and professional training to over 600 persons. In addition, PHS facilities provide on-the-job experience to about 1,200 allied health personnel, such as nursing assistants, dental hygienists and assistants, orthopedic assistants, and laboratory technicians.

Budget Request

An amount of $1,600,000 is requested in 1975 to provide health care to the participants in the Public Health Service study of untreated syphilis. Health care will also be provided to members of their immediate families. The balance of the 1975 request reflects continuation of the 1974 programs, allowing for mandatory increases. Obligations include estimated reimbursements to be received principally for care provided in PHS hospitals to foreign seamen and beneficiaries of other Federal agencies.

Coast Guard Medical Services

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	151	$3,070,000	151	$3,127,000	---	+$57,000
Other expenses........	---	5,084,000	---	5,217,000	---	+133,000
Total...........	151	$8,154,000	151	$8,344,000	---	+190,000

The budget estimate provides for medical services to Coast Guard personnel aboard their vessels and at their air and other shore stations. It also provides for care in contract medical facilities, hospitalization in Federal facilities other than those operated by the Public Health Service, and emergency medical treatment in non-contract facilities as authorized by law. Not included in this budget for medical services are costs funded by the Coast Guard such as space, utilities, medical and dental equipment, mobile dental units, furniture, office appliances, and pay and travel allowances of Coast Guard personnel assigned to the program.

Full-time medical, dental, and ancillary staff are assigned where sufficient concentrations of personnel exist to make operation of such facilities economical to the Government. When USPHS facilities are inaccessible, contract care is provided by the utilization of civilian or other Federal agency health care facilities. Drug abuse and alcohol rehabilitation programs are in operation to provide prevention, detection, treatment, and rehabilitation of personnel. In addition, the major recruit training centers are operating facilities to rehabilitate personnel with minor psychological disorders. To enable the Coast Guard to meet its military and other commitments, we are attempting to broaden the scope of the health care delivery system to include industrial, environmental, aviation, and underwater medical services.

Health care facilities of the Coast Guard medical program are as follows:

Major shore facilities	10
Minor shore facilities and dispensaries	84
Mobile dental units	9
Vessels	
High endurance cutters and icebreakers	30
Small ships	59
Total facilities	192

The funds requested for 1975 would be used to continue the program at its current level. The increase of $190,000 is for mandatory items such as statutory salary increases and price increases for medical supplies and contract medical care.

Federal Employee Health Services

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...........	264	$3,866,000	264	$3,927,000	---	+$61,000
Other expenses...........	---	1,699,000	---	1,699,000	---	---
Total................	264	5,565,000	264	5,626,000	---	+61,000
Reimbursable obligations........		-5,000,000		-5,047,000		-47,000
Direct obligations...		565,000		579,000		+14,000

Responsibility for Federal employee health is assigned to the Public Health Service under P.L. 79-658, August 8, 1946 (5 USC 7901), and the Bureau of the Budget Executive Circular No. A-72, June 18, 1965.

The services authorized include emergency diagnosis and treatment of injury or illness occurring during working hours; pre-employment examinations; inservice examinations determined necessary by the Department or agency head; administration of treatments and medications under certain circumstances; preventive services to appraise and report work environment health hazards; health education, and specific disease screening examinations and immunizations; and referral to private physicians, dentists, and other community health resources. The specified goal is the provision of these services for all Federal employees who work in groups of 300 or more.

The Division of Federal Employee Health has established the following objectives:

a. To provide consultation on the organization and establishment of employee health services to any Federal agency requesting advice; to provide standards and criteria for the furnishing of such employee health services; and, when requested, to assist agencies of the Government in the evaluation of such services.

b. To organize, administer, and operate Federal employee health services for participating Federal agencies on a reimbursable basis.

In 1975, it is expected that over 100 health units will be operating under this activity, providing occupational health services to an estimated 180,000 Federal employees. This continues the level of operation reached during 1974. The requested increases of $47,000 in reimbursable funds and $14,000 in appropriated funds are for built-in items of expense.

Payment to Hawaii

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses............	---	$1,200,000	---	$1,200,000	---	---

Federal legislation was passed on June 25, 1952, providing for payments to the Board of Health of the Territory of Hawaii for the care and treatment in its facilities of persons with Hansen's disease. Funding for this program began in F.Y. 1953 in the amount of $500,000; from F.Y. 1954 thru F.Y. 1960, $1,000,000 was appropriated each year, and from F.Y. 1961, $1,200,000 has been appropriated annually.

It should be noted that reimbursement is based on actual expenses so that the requested amount will not be paid unless it is actually needed. Any expenses above the $1,200,000 are borne by the State of Hawaii.

The table below shows the estimated average daily patient load, patient days, per diem cost, and appropriation requests for 1974 and 1975.

	1974	1975
Average daily patient load......	143	140
Patient days....................	52,200	51,000
Inpatient per diem cost.........	$35.33	$36.57
Inpatient cost..................	$1,844,000	$1,865,000
Outpatient cost.................	36,000	43,000
Total cost..................	1,880,000	1,908,000
Appropriation request........	1,200,000	1,200,000

Buildings and Facilities

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses..............	-	$12,000,000	---	$5,027,000	--	-$6,973,000
Budget authority............	---	($14,250,000)	---	($1,300,000)	--	(-$12,950,000)

The facilities of the Federal Health Programs Service include a system of eight Public Health Service hospitals, the Leprosarium at Carville, Louisiana, and 26 outpatient clinics.

The 1975 budget requests $1,300,000 to support remodeling projects at three existing outpatient clinics and for the relocation of three outpatient clinics. It will also support three major improvement projects at the Carville hospital.

The 1974 appropriation provided funding for repair and modernization of the PHS hospitals. These facilities are about 40 years old and none has had significant improvement or modernization in recent years. We are now developing a plan for use of the appropriated funds.

Program Management

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..........	893	$19,166,000	903	$18,825,000	+10	-$341,000
Other expenses..........	---	14,011,000	---	16,958,000	--	+2,947,000
Total.............	893	$33,177,000	903	$35,783,000	+10	+$2,606,000

Subactivities:						
a. Bureau of Comm. Health Services..	627	$26,367,000	637	$24,534,000	+10	-$1,833,000
b. Patient Care and Special Health Services.........	95	2,893,000	95	2,813,000	--	-80,000
c. Office of the Administrator....	171	3,917,000	171	3,907,000	--	-10,000
d. Payment to GSA.............	---	---	---	4,529,000	--	+4,529,000
	893	$33,177,000	903	$35,783,000	+10	$2,606,000

Introduction

The Program Management activity provides for a staff of 903 positions and $35,783,000.

The primary purpose of this activity is the administration and provision of program support to the Bureau of Community Health Services, and Patient Care and Special Health Services programs. Provision is also being made for the payment of rent to the General Services Administration. In addition, the Office of the Administrator provides for the overall planning, direction and administration of the Health Services Administration programs.

a. Bureau of Community Health Services:

The primary purpose of this subactivity is to provide national leadership and direction to legislatively mandated programs, and to provide full support to the decentralized grant programs of the Bureau of Community Health Services.

The headquarters staff is responsible for activities such as (1) the development of policies, regulations, guidelines, and standards for the health care delivery programs; (2) applied research and training in program areas for the improvement of health services delivery; (3) development of policies, guidelines, and mechanisms for the improvement of financial aspects of the programs, such as maximization of third-party reimbursements; (4) development and testing of improvements in the organization and structure of health care delivery systems; (5) development and implementation of standards for measuring project performance and quality; and (6) planning, monitoring, and analysis activities to improve program management and assure the most effective allocation of resources. In addition, the headquarters staff provides overall program direction and management support for the programs of the Bureau of Community Health Services, performs national reporting and analysis activities, and provides specialized program back-up to the regional offices and grantees.

The regional staff has the primary responsibility for project grant administration for four major programs: community health centers, maternal and child health, family planning, and migrant health. The regional staff also provides technical assistance and program guidance to present and potential grantees in the four major programs' areas. Regional office staff also furnishes program support to National Health Service Corps field assignees.

For 1975, an increase of 10 positions over the 1974 comparable level and a net decrease of $1,833,000 is shown in this request. The net decrease reflects the following: (1) mandatory increases amount to $693,000 (2) a program increase of $50,000 for the 10 new administrative positions to support the increased number of corps field assignees; (3) a decrease of $1,729,000 representing a reduction in contract requirements; and (4) decreased costs of $832,000 resulting from the 1974 reduction of 53 Maternal and Child Health positions which supported the project grant authority that will terminate in 1975; (5) a decrease of $15,000 for one-time equipment costs.

The National Health Service Corps will continue the assignment and support of health professionals and allied health workers in communities designated as critical health manpower shortage areas. The requested increase of 146 field positions for the Corps will allow it to serve an additional 55 communities, above the present level of 405 field positions serving 220 communities. The 10 new positions within this subactivity will augment the Regional Office technical assistance effort to field stations and communities, in line with the increased level of Corps activity. The increase will also assist the efforts of the Corps to strengthen its relationships with professional associations and community groups, while attempting to reduce the communities' dependence on the Federal government. Central Office staff will concentrate on two major activities: recruitment of new health personnel; and general improvement of administration by development of policies, guidelines and procedures that are necessary for the efficient operation of a mature program.

High priority will be given to securing increased third-party payments in existing projects which have demonstrated a capacity to obtain these payments. Emphasis also will be on improving project management and quality of care delivered through all Bureau of Community Health Services funded service programs.

The conversion of Maternal and Child Health project grants to formula grants as provided by Section 502 of the Social Security Act will be implemented in 1975. This will require States to plan and develop new projects as required by law. Assistance will be provided to the States for this purpose.

A major accomplishment during fiscal years 1973 and 1974 has been the transfer of OEO projects relating to community health services and family planning to the Bureau of Community Health Services. Many of the transferred family planning projects have been consolidated with existing projects, resulting in improved program and management capabilities. All transferred projects will be reviewed in relation to current HEW program priorities and receive assistance in improving their management and increasing third-party reimbursements.

Another accomplishment was the initiation of systematic approaches to increase the level of third-party reimbursements in approximately 800 Bureau of Community Health Services funded health service delivery projects. This required a strengthening of the financial planning, management and collection capabilities of the projects. Besides an increased level of third-party financing, an important benefit to be gained will be the better preparation of all health services delivery projects to relate to expanded national health service financing programs.

The reorganization of the program and support staff of the components of the Bureau of Community Health Services was also accomplished in 1974. This reorganization has resulted in a functional alignment of headquarters staff with greater flexibility in staff utilization and improved coordination among the programs administered by the Bureau. The reorganization has also improved the ability of the Central Office to function in the context of a decentralized program.

b. Patient Care and Special Health Services:

The 1975 request for this subactivity includes $2,813,000 and 95 positions which represents a net decrease of $80,000 for non-recurring equipment and contract costs. This request supports the Federal Health Programs Service headquarters offices which provide the management necessary to direct the operations of the eight PHS hospitals, the National Leprosarium at Carville, Louisiana, 26 outpatient clinics, the Coast Guard medical program, and 103 Federal employee health units.

The major objective in 1975 will be to develop alternative ways of operating the PHS hospitals to ensure that they are maximally utilized.

c. Health Services Administration, Office of the Administrator:

The 1975 request for this subactivity includes $3,907,000 and 171 positions. It supports a central staff necessary to planning, direction and administration of the broad scope of programs and activities in the Health Services Administration. Support is provided the Administrator in the formulation of policies and program plans, and in evaluating Agency progress in mission accomplishment. Also, staff assistance is provided in the areas of contracts and grants administration, financial management, personnel management, property management, legislative services, communications and public affairs, equal employment opportunity, and general services.

In 1975 the principal objectives of the Office of the Administrator are to structure, implement, move-forward, and oversee the following major new program initiatives:

(1) Health Maintenance Organization legislation - staffing an appropriate organization, the developing of regulations and guidelines, the structuring of a review process for the award of funds, designing of an accountability mechanism, and the funding of projects.

(2) Professional Standards Review Organization provisions of the Social Security Act (P.L. 92-603) - concluding agreements for implementation

activities with the Social Security Administration and the Social Rehabilitation Service, the providing of technical assistance to developing PSROs and State councils, staffing an appropriate organization, and the development of regulations and guidelines.

(3) Emergency Medical Service Systems - staffing, developing of regulations and guidelines, and the funding of projects.

(4) Third-Party Reimbursement - implementing of procedures to increase the level of support to PHS funded health care projects.

In addition, the Office of the Administrator will provide policy and program leadership, and monitor and evaluate progress in achieving ongoing program objectives relating to the health status of American Indians and Alaska Natives, direct health care to Federal beneficiaries, family planning, maternal and child health services, neighborhood health centers, the National health service corps, and the Federal employee health program.

d. Payments-General Services Administration:

This budget proposes an increase of $4,529,000 to cover the cost of rental payments to GSA for building space occupied by the organization supported by this appropriation. Heretofore, these costs were borne directly by GSA rather than by the individual agencies. The enactment of the Public Buildings Amendments of 1972 (P.L. 92-313) and the implementation of the Federal Buildings Fund requires that the rental charges be made directly to the using organization for the buildings under GSA control.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Community health centers
(PHS Act, Section 314(e))

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$205,500,000	1/	---	$200,400,000

Purpose: This program provides a mechanism for meeting special health needs of people regionally, for meeting those needs considered to be of national significance, and for developing and initially supporting new health services programs. It also provides an effective means for upgrading and expanding the capacity to provide ambulatory health services in medically underserved areas and allowing response to health needs of specific groups either enrolled in projects or residing within limited geographic boundaries.

Explanation: Under Section 314(e) of the PHS Act, project grants are awarded to public or nonprofit private agencies, institutions or organizations to support ambulatory health service programs which provide primary care and develop arrangements for the provision of specialty and inpatient care.

Accomplishments in 1974: In 1974 approximately 118 community health centers have provided a range of preventive, therapeutic, and rehabilitative ambulatory services to an estimated target population of 4,660,000. The centers include former OEO projects which have been transferred to DHEW over the past several years. The number of people receiving services in these centers is estimated at 1,200,000.

There are also 39 family health centers. In 1974, 25 of these centers will be operational and the remaining 14 will be completing their developmental work. It is estimated that the operational centers will serve approximately 35,000 people.

Significant activity centers around working with health centers to enable them to improve their overall management capabilities, particularly financial management. A major financial inventory team site-visit approach was initiated with the intent of identifying critical financial management issues and of increasing third-party reimbursement levels through improved project administration and management. The original HEW community health centers have engaged in this process and it is expected that the newly transferred OEO centers will complete the process by the end of 1974. Current plans call for using the site-visit financial inventory approach for all community health centers and family health centers which receive over $500,000 in grant support. Projects receiving less than $500,000 will engage in approaches involving cost accounting procedures, training, and audit guide to improve their financial management.

1/ Authorization expires June 30, 1974. Extension being proposed.

Efforts with respect to third-party reimbursements have also been fostered through the development and implementation of data systems. All centers, including those newly transferred from OEO, are expected to be meeting the reporting requirements by the end of this fiscal year.

Objectives for 1975: A major priority will be to continue efforts to set realistic third-party collection targets, to improve the financial management capabilities of the centers, and to promote a technical assistance program to help community health centers achieve and maintain program objectives.

The $5,100,000 decrease in direct Federal funding for community health centers will be counter-balanced by expected savings resulting from internal project management improvements and will not adversely affect the number of patients served or the quality of services. In 1975 an estimated 1,320,000 will receive services as compared with 1,200,000 in 1974.

Further, a substantial initiative to improve the quality and efficiency of services will be mounted. In addition to maintaining outside evaluation of the quality of health center services, projects will be assisted in developing, conducting and utilizing their own quality of care assessments. Projects will also be encouraged to develop improved strategies for attracting and keeping high quality physicians and other health providers and to attack high priority community health problems, such as infant mortality and hypertension.

The family health center efforts will continue support of the 39 projects. It is anticipated that at least 30 projects will be operational and that an estimated 105,000 people will be served in 1975, an increase of 70,000 over 1974. This increase will be due to expansion of service delivery in current operational projects as well as the addition of people served from about five more projects expected to become operational in 1975.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Comprehensive health grants to States (PHS Act, Section 314(d))

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
63	$90,000,000	1/	63	$90,000,000

Purpose: These formula grants are awarded to the States' public health authorities to assist the States in establishing and maintaining adequate public health services in accord with priorities and goals established by the States.

Explanation: Under Section 314(d) of the PHS Act, grant allocations are based on a State's population and per capita income.

Accomplishments in 1974: State health and mental health agencies have utilized their funds to assist in the support of a broad range of basic health programs provided at the State and local level. Among the ongoing activities that provide health services to both the general population of the States and to high-risk groups within the States are communicable disease control, environmental health programs, laboratory services, vital statistics, nursing services, and a variety of community mental health services. In addition to supporting services which benefit all citizens, these funds are expended for personal health services such as cervical cancer screening, immunization and hypertension. Some States use the flexibility of these funds to support new approaches to the delivery of these health programs; others have expanded into new areas of services for their State and local health agencies, such as family planning, dental and medical care clinics.

Objectives for 1975: The 1975 budget request would allow the States to continue the same level of support for their public health programs as in 1974.

1/ Authorization expires June 30, 1974. Extension being proposed.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Maternal and child health grants to States (Social Security Act as amended through 1967, Sections 503 and 504)

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$243,951,000 1/	Indefinite by activity 2/	---	$243,951,000

Purpose: Grants to States for maternal and child health and crippled children's services are designed to (1) reduce infant mortality and otherwise promote the health of mothers and children, and (2) locate, diagnose, and treat children who are suffering from crippling or other handicapping illnesses. Project grants provide comprehensive health care to poor and near-poor mothers and children who might otherwise not receive such services.

Explanation: Grants are made to States on a formula basis and to State agencies and public or nonprofit institutions of higher learning for special projects of regional or national significance which contribute to the health of mothers and children, including crippled and mentally retarded children. In both the maternal and child health services and crippled children's services formula grant programs, one-half of the amount appropriated in each case is apportioned among the States on a population-related formula basis and must be matched dollar-for-dollar. From the remaining half of the appropriation, specified amounts are reserved for special project grants and the balance is apportioned by formula (inverse population and per capita income ratio) among the States. Matching is not required for funds awarded from the second half of the appropriation.

Section 502 of the Social Security Act provides that for the fiscal year beginning July 1, 1974 and each year thereafter, 90 percent of the appropriation shall be for allotments pursuant to Sections 503 and 504. The allotment of 90 percent of appropriation by formula in 1975 and each year thereafter will result in significant changes in the States' maternal and child health programs. Whereas at present 36 States have maternity and infant care projects, beginning in 1975 all States will be required by statute to have a program of maternity and infant care projects. Similarly, all States will have children and youth projects, whereas at present, 31 States have such projects. Each State program will also include dental care, neonatal intensive care, and family planning projects.

1/ This amount is distributed as follows: $125,678,000 for Grants to States (Sections 503 and 504), $111,273,000 for Project Grants (Sections 508, 509, 510) and $7,000,000 for Grants to States (Section 516).

2/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

Accomplishments in 1974--Grants to States: The 1974 program continued to provide a variety of health services to mothers and children, including the following:

	1974 Estimate
Mothers receiving prenatal and postpartum care in maternity clinics	359,000
Women receiving family planning services	1,017,000
Children attending well-child conferences	1,500,000
Children receiving nursing services	2,700,000
Crippled children receiving physicians' services	500,000
Children receiving dental treatment	800,000

Project grants: The 1974 program has been designed to provide a variety of services to poor and near-poor mothers and children in order to improve their health status. The following are some of the services provided and estimates of numbers of individuals reached:

	1974 Estimate
Admissions for comprehensive services:	
Mothers	142,000
Infants	47,000
Women receiving family planning services	115,000
Children registered for comprehensive health care	483,000
Children cared for in dental projects	21,000

Objectives for 1975: In 1975, services formerly provided under project grants will be funded through the State grant mechanism. The 1975 program will continue to provide a variety of health services to mothers and children at about the same level as in 1974.

	1975 Estimate
Mothers receiving prenatal and postpartum care in maternity clinics	501,000
Infants admitted for comprehensive services	47,000
Women receiving family planning services	1,432,000
Children attending well-child conferences	1,500,000
Children receiving nursing services	2,700,000
Crippled children receiving physicians' services	500,000
Children registered for comprehensive services	483,000
Children receiving dental treatment	821,000

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services--Maternal and child health research and training (Social Security Act as amended through 1967, Sections 511 and 512)

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$21,917,000	Indefinite by activity 1/	---	$21,917,000

Purpose: These programs are designed to improve health and medical services to mothers and children through applied research and through training of personnel involved in providing health care and related services to mothers and children, particularly mentally retarded and multiply-handicapped children.

Explanation: Primary effort has been given to support of training in university-affiliated centers for the mentally retarded. These centers provide specialized clinical training in a multidisciplinary setting for physicians and other health personnel who focus their activity on the multiply-handicapped child. Grants to public or nonprofit institutions of higher learning provide support for faculty, traineeships, services, clinical facilities and short-term institutes and workshops. Research grants and contracts are made with public or nonprofit private agencies and appropriate research organizations. The research effort is concerned with mothers and children in all classes of our society, with high priority given to special problems for those segments of the population not receiving adequate health care.

Accomplishments in 1974: The training program provides staffing support for a total of 20 university-affiliated mental retardation centers in geographically dispersed areas. The primary effort of these centers has been to support advanced training of professionals in maternal and child health fields. In addition to supporting training for 300 individuals in 1974 these centers offer a complete range of services for mentally retarded and multiply-handicapped children. The 1974 program also provides for training of up to 150 nurse midwives, pediatric nurses and other physicians' assistants. This program, which was initiated in 1972, is separate from the training efforts of the university-affiliated centers.

The research program through 68 projects, is focused on improving health and medical services to mothers and children. Two of its major undertakings concentrate on evaluation and assessment of the comprehensive medical care projects. Other accomplishments include important findings in nutrition related to maternal and infant health, and development of a Clinic Self-Evaluation Manual for improving services of outpatient clinics.

Objectives for 1975: The 1975 budget continues the training and research programs at the same level as in 1974.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Family planning project grants and contracts (PHS Act, Title X)

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$100,615,000	1/	---	$100,615,000

Purpose: The goal of the family planning service program is to provide a full range of high quality family planning services to all women who might want such services but cannot afford comprehensive family planning services.

Explanation: Project grants are made under Title X of the Public Health Service Act to State and local health departments and other public or nonprofit private organizations to provide family planning services. Title X authorizes project grants and contracts for the training of family planning workers, studies of new and improved methods of delivering family planning services, and the development and distribution of family planning education materials.

Accomplishments in 1974: Successful project consolidation efforts will reduce the number of grants which must be administered from approximately 500 to approximately 350. These efforts are expected to result in lower unit costs with no reduction in the number of women served. Approximately 1,900,000 persons will receive services during 1974.

Project grants and contracts totalling $6,115,000 will be awarded for the short-term training of family planning workers; the development and distribution of improved educational materials related to family planning; and for operational research, planning and evaluation, and technical assistance to improve the delivery of family planning services. Over 5,000 people received short-term training related to family planning in 1973 and a similar number is expected in 1974. Technical assistance was provided to the HEW regional offices, State and local governments, and private agencies on a short-term (less than 30 days) basis. These activities consist of task-oriented aid and guidance ranging from basic matters such as setting up records through more complex issues such as increasing the usefulness of reports or coordinating patient follow-up with patient scheduling, improving project community relations or conducting special cost analysis studies.

1/ Subject to extension of PHS Act Title X which expires June 30, 1974.

Objectives for 1975: In 1975, priority will be given to improving program management capabilities and accounting practices in order to assist grantees to obtain third-party reimbursements. The increased reimbursements from third-party sources such as Medicaid and AFDC social services will enable projects to serve additional women. The total number of women served by all sources, including private physicians, is expected to total over 5,000,000 in 1975.

Emphasis will continue on consolidating or coordinating existing grants within States or designated areas to improve the efficiency of services delivery. The integration of family planning services into regular health care settings will continue to be a priority, as will the monitoring of medical care standards.

The training grants and contracts program level of $3,000,000 will continue to provide direct short-term training to approximately 5,000 family planning professional and allied health workers in 1975.

The family planning education program of $600,000 will permit the continued dissemination of useful, appropriate information about family planning techniques to potential consumers so that they may be better able to voluntarily determine the utilization of services and the size of their families.

The services delivery improvement contract program of $2,515,000 will continue to emphasize technical assistance to grantees in the areas of program development and management. The technical assistance effort will be used to assist grantees in developing data management techniques and accounting systems to facilitate the collection of third-party reimbursements and in utilizing patient data for program planning, management and evaluation purposes. The technical assistance effort in 1975 will also support the implementation of research findings on how to better serve hard-to-reach consumers such as adolescents, rural people, low-income workers and the handicapped.

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HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services — Migrant health (PHS Act, Section 310)

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$23,750,000	1/	---	$24,000,000

Purpose: This program provides access to health care services to migrant and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population.

Explanation: Under Section 310 of the PHS Act, support is provided to finance part of the costs (no specific matching requirement) of establishing family health services clinics and to improve the health services and health condition of agricultural migrant workers and their families by providing health care services.

Accomplishments in 1974: In 1974, 355,000 persons are expected to receive services, involving about 630,000 patient visits. Otherwise, program efforts will continue along lines similar to 1973, with emphasis on improved management and attempts to secure higher levels of reimbursements. A uniform utilization and cost data reporting system will be implemented in 1974, which will have the potential to provide projects with data to assist them with management, evaluation and planning.

A special project, designed to gather and evaluate data on hospital utilization and cost of hospital services for a selected migrant population, was initiated in 1974 at a level of $3,000,000. The Bureau of Health Insurance, SSA, serves as the fiscal intermediary for reimbursing hospitals for care provided to eligible migrants in this demonstration. Six migrant health projects have initiated programs with nine hospitals to provide access to inpatient services at a fixed daily rate for approximately 50,000 migrants.

As a result of a survey and analysis to determine the nature of sanitary conditions at selected migrant camps, active coordination efforts, with Labor Department officials responsible for occupational health and safety, will be emphasized in order to accomplish corrective measures in the sanitation area.

Objectives for 1975: Activities will continue generally at current levels. Projects will be assisted in improving their fiscal management capabilities to secure additional third-party reimbursements; analysis of the hospitalization experience will begin; and utilizing the $250,000 requested increase, limited experimental efforts will be directed to improving service delivery in low impact areas.

1/ Authorization expires June 30, 1974. Extension being proposed.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Health maintenance organizations
(PHS Act, Section 301 and Title XIII)

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
100	$65,000,000	1/	125	$60,000,000

Purpose: The Health Maintenance Organization Act of 1973 (P.L. 93-222) provides authority for a five-year program of assistance to promote the development of new and expansion of existing health maintenance organizations (HMOs). The legislation is based on the concept that assistance to HMOs is one of the more effective means of dealing with specific major problems in health care today, such as:

- -- the rapid inflation in medical costs
- -- the inadequate emphasis on illness prevention
- -- an increasing unevenness in the distribution and quality of medical care.

HMOs provide comprehensive health services on a prepaid, capitation basis with emphasis on primary care, preventive services, and efficiency of operations.

Explanation: Financial assistance is provided to public and private non-profit HMOs in the form of grants and contracts for feasibility studies, planning and initial development, and loans to help cover operating costs during the first three years of operations. Profit-making HMOs are eligible for loan guarantees for planning, development, and initial operating costs if they will serve medically underserved populations. Priority for all types of assistance will be given to HMOs which will serve such populations; 20% of the funds are set aside for rural HMOs. The request includes $15,000,000 to provide additional capitalization of the HMO Direct Loan and Loan Guarantee Fund. This will be a revolving fund; loans will be sold to provide funds for new loans, with loans thus sold becoming guaranteed loans. The request of $5,000,000 is for program support which includes the costs for 125 positions and contracts for technical assistance to developing HMOs.

1/ Financial assistance grants and contracts (1309(a)), $55,000,000; direct loans (1309(b)), $75,000,000 in the aggregate for 1974 and 1975; loan guarantees (1308(d)), indefinite; program support (301), indefinite.

Accomplishments in 1974: An estimated 20 new HMOs will become operational in 1974 through funds requested as a supplemental appropriation. The average loan amount is estimated at $500,000 per year. These new HMOs have an estimated eventual enrollment of approximately half a million people. The financial assistance grants and contracts program will support an estimated 128 projects, as shown in the accompanying table. Program support objectives for 1974 include the recruitment and training of staff; development of regulations for the grant and contract program; establishment and implementation of processes for allocation of funds and review of applications; making initial awards of financial assistance; implementation of the loan fund; and provision of technical assistance. Liaison will be established with other Federal agencies for the purpose of beginning the certification of qualified HMOs eligible for the dual-choice provisions of Title XIII, as well as with agencies responsible for the purchase of health care for their beneficiaries.

Objectives for 1975: The loan fund will provide assistance to about 38 operational HMOs, including 18 which will begin operations in 1975. The 38 new HMOs will have an estimated eventual capacity to serve approximately 1,000,000 people. Grants will be awarded to assist new HMOs in their various stages of development, as shown by the table below. Most of the 25 new positions will be allocated to regional office staff, which will assume an increasingly important role in carrying out the program, through monitoring of assisted and certified HMOs. Certification of qualified HMOs eligible for the dual-choice provisions of Title XIII, and liaison with the Department of Labor to assure the compliance of employers with those provisions will be expanded as existing labor contracts expire. A system for marketing direct loans to replenish the loan fund will be implemented.

	1974		1975	
HMO Activity	No.	Amount	No.	Amount
Feasibility studies	60	$3,000,000	60	$3,000,000
Planning	48	6,000,000	48	6,000,000
Initial development	20	16,000,000	39	31,000,000
Loans	20	35,000,000	38	15,000,000
Program support		5,000,000		5,000,000
Total	148	65,000,000	185	60,000,000

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Community health services -- National health service corps (PHS Act, Section 329, as amended)

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
405	$9,849,000	1/	551	$9,255,000

Purpose: The purpose of the National Health Service Corps is to alleviate the critical health manpower shortage by providing health professionals to communities where shortages exist.

Explanation: This activity is responsible for the recruiting and assigning of appropriate health personnel to critical health manpower shortage areas and assisting communities in the development of self-sufficient local health delivery systems.

Accomplishments in 1974: As of January 31, 1974, there were 340 health professionals (240 doctors, 38 dentists, 43 clinical nurses and nurse practitioners, and 19 other allied health personnel) assigned to 183 communities. Despite discontinuation of the "doctor draft", the Corps has recruited a pool of health provider personnel. From this pool, 188 health professionals, including 137 physicians and 25 dentists, will be placed in communities with health manpower shortages by June 30, 1974. The placement of these personnel to fill vacancies and to staff positions in approximately 30 new sites will utilize the 405 positions authorized for FY 1974. In addition, 50 personnel, available for placement in shortage areas in July, have been recruited.

During FY 1974, the National Health Service Corps more clearly defined its program functions and strengthened its relationships with professional associations and community groups. The confrontation of problems with management of sites, principles of medical practice, community support in the form of equipment and supplies, and review and evaluation of Corps sites resulted in the development of useful procedures in program operations. The Corps will continue to develop and improve regulations, policies and procedures, as well as criteria for community designation. Program activities continue to assist community sites in developing self-sustaining capabilities to manage a local primary care delivery system.

1/ Authorization expires June 30, 1974. Extension being proposed.

Emphasis has been placed on developing an effective long-term recruitment program for provider personnel with special emphasis on physician recruitment. A major activity has been assisting community groups in setting up programs that link assignees to other provider units, These programs, that foster improved systems of care and develop professional and personal relationships, will greatly improve the possibility of the health provider's remaining in the community. The Corps' retention rate for 1974 will be 25% compared to 3% for 1973. Because of improved matching techniques and community assistance activities, this rate should increase in 1975.

Objectives for 1975: This request will permit the recruitment of an additional 146 health personnel who, when recruited, will serve approximately 55 additional communities. It will also continue the support of 405 health professionals in approximately 220 communities with critical health manpower shortages.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Quality assurance (PHS Act, Sections 301 and 311)

	1974		1975		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Budget Authority	---	---	---	---	---
Obligations	224	$5,613,000	Indefinite	224	$5,774,000

Purpose: The Bureau of Quality Assurance provides the professional health expertise necessary for implementing the Department's responsibilities, through standard setting and enforcement, for assuring the health and safety of Medicare and Medicaid beneficiaries, as well as the appropriateness and quality of services provided to such beneficiaries.

Explanation: This activity provides for the development of specialized programs related to medical care administration, including the professional health aspects of Title XVIII of the Social Security Act. The Bureau accomplishes its objective by participating with the Bureau of Health Insurance (SSA) and the Medical Services Administration (SRS) in the development, interpretation and evaluation of program regulations, policies and procedures, and in the field administration of such program requirements.

Accomplishments in 1974: A complete review and revision of Medicare conditions of participation and the certification procedures for providers of services (hospitals, skilled nursing facilities, home health agencies) and independent laboratories, was completed in 1973 and final regulations will be issued this year.

Experimental standards for ambulatory health care centers were developed and field tested in 1973 and such standards will be applied and their effects evaluated in 1974.

A major responsibility stemming from the Social Security Amendments of 1972 (P.L. 92-603, Section 2991) concerns the End-Stage Renal Disease Program. Planning for and development of interim regulations occurred in 1973. In 1974 the interim program will be conducted, the development of the conditions of participation for the long-range program will begin, and the medical review boards will be established.

Planning for the consolidation of standard setting and certification responsibilities as they affect all providers of service under Medicare and/or Medicaid will be conducted in 1974 in BQA and PHS regional offices. To help ensure effective application of Medicare quality standards, physicians, nurses, and other health services specialists are assigned to regional offices to implement program policies, regulations and guidelines and provide continuing assistance and consultation to State Medicare and Medicaid agencies and regional BHI and MSA staff. The resulting upgrading of facilities and services accomplished through the Federal-State partnership has benefited persons of all ages, has strengthened State licensure statutes and regulations for health facilities, has had a positive effect on voluntary accrediting programs, and will provide the base for future quality assurance methods especially under a national health program.

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Objectives for 1975: The Bureau of Quality Assurance will continue to implement Public Law 92-603 provisions for which it has a responsibility. Of prime importance will be the development and implementation of the conditions of participation for facilities participating in the end-stage renal disease treatment program. Data collection and evaluation of program experience during 1974 will be conducted.

Implementation of the standards consolidation activity will take place with realignment of staff, responsiblities and reporting channels. Continued emphasis on surveyor improvement programs will occur.

Continued regional office and State agency evaluation of Medicare and Medicaid provider standards through program review will occur in a stepped-up fashion. Objective performance assessment will become the method used for such review.

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HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Patient care (PHS Act, Sections 301, 311, 321, 322, 324, 326, 328, 331, 332, 502, 504, and 42 U.S.C. 253a)

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
5,084	$94,749,000	Indefinite	5,084	$99,061,000
Obligations				
5,084	109,914,000		5,084	114,226,000

Purpose: The primary purpose of this program is to provide for the comprehensive health care of American seamen, Coast Guard and PHS Commissioned Corps personnel, and persons with Hansen's disease. On a reimbursable basis, health care is also provided in PHS hospitals and outpatient clinics to foreign seamen and beneficiaries of other Federal agencies.

Explanation: To carry out this mission, funds have been appropriated to operate Public Health Service hospitals and clinics and, where necessary, to provide for care of primary beneficiaries through contractual arrangements with other Federal and non-Federal hospitals, and with private physicians and dentists. Medical care is also provided to beneficiaries of other Federal agencies on a reimbursable basis.

Accomplishments in 1974: Health care was made available to an estimated 500,000 PHS beneficiaries, in addition to foreign seamen and beneficiaries of other Federal agencies. In the hospitals, there was a daily average of 1,520 inpatients and an annual total of 1,470,000 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities averaged 99 inpatients per day; in addition, 68,000 outpatient visits were made to private physicians and dentists. Recruitment efforts for hiring physicians, nurses, and other medical employees were intensified to rebuild staff that the hospitals had been losing over the past few years.

Objectives for 1975: The budget for 1975 provides for continued operation of the PHS hospital and clinic system while undertaking a study on how these hospitals might be best utilized. With the expected increase in professional staff and treatment capabilities resulting from recruitment efforts, the patient workloads in PHS hospitals and clinics will increase as the table below shows:

Workload:	1974	1975	Change
Average daily patient load in PHS hospitals	1,520	1,778	+258
Outpatient visits to: PHS hospitals	745,000	792,000	+47,000

	1974	1975	Change
PHS outpatient clinics	725,000	765,000	+40,000
Contract care:			
ADPL in non-PHS hospitals	99	89	-10
Contract physician visits	68,000	64,000	-4,000

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Coast Guard medical services (PHS Act, Section 326)

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
151	$8,154,000	Indefinite	151	$8,344,000

Purpose: The Coast Guard Medical Program, under the direction of the Chief Medical Officer, U. S. Coast Guard, provides for delivery of health care to personnel who support the operational mission of the Coast Guard at its air and shore stations and aboard its vessels. Coast Guard personnel are also provided inpatient, outpatient and emergency medical care and services on a contractual basis in areas without PHS facilities or in cases needing special care.

Explanation: Appropriated funds are used to finance health care provided through a system of medical facilities classified as dispensaries and sick bays, and by contract with other hospitals, physicians, and dentists. Where sufficient concentrations of personnel exist, large dispensaries with full-time medical, dental, and ancillary staff provide comprehensive care to authorized beneficiaries. Smaller concentrations of personnel are served by smaller dispensaries and sick bays which may have medical and dental officers assigned or may be staffed by Coast Guard hospital corpsmen. In many instances, small concentrations of personnel are provided health care by local contract physicians, dentists, and hospitals, as well as through utilization of Federal medical facilities where available. The Coast Guard operates one accredited hospital, located at the Coast Guard Academy, New London, Connecticut.

Accomplishments in 1974: In 1974, care was made available to approximately 138,000 Coast Guardsmen (active duty and retired) and their dependents. Outpatient medical and dental visits by all beneficiary classifications were in excess of 600,000. A total of approximately 14,000 inpatient days were recorded in Coast Guard medical facilities. Currently, care is being provided for 100 patients a year, for four months each, at alcoholic rehabilitation centers.

Objectives for 1975: Objectives in 1975 will be to meet the needs of the beneficiary population of approximately 138,000. Programs started in prior years will be continued and expanded to the extent possible. Efforts to improve the effectiveness of health care delivery in pursuit of the above stated objectives will continue.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Federal employee health services (P.L. 79-658, August 8, 1946, 5 USC 7901)

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
264	$565,000	Indefinite	264	$579,000
Obligations				
264	5,565,000		264	5,626,000

Purpose: Appropriated funds for Federal employee health services provide for consultation to and surveys of Federal agencies on the conduct of Federal employee occupational health programs. This program also operates health units providing selected services for Federal agencies on a reimbursable basis.

Explanation: Prior to establishing a Federal employee health program, all Federal agencies must, by law, consult with the Public Health Service regarding program standards. The appropriated funds provide for consultation services to any Federal agency, on request, on the establishment or evaluation of Federal employee occupational health programs. Within its capabilities, the Public Health Service also provides, under reimbursable authority, direct clinical health services to Federal agencies on request.

Accomplishments in 1974: In 1974 over 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. By the end of 1974, health care services will have been provided to approximately 180,000 Federal employees in 103 health units.

Objectives for 1975: The estimate for 1975 will permit maintenance of employee health activities at the same level reached in 1974. The program will continue to be responsive to other Federal agencies for requested consultation and evaluation of their occupational health programs. It will also continue operation of 103 health units providing services to approximately 180,000 Federal employees.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Payment to Hawaii (PHS Act, Section 331)

1974	1975 Authorization	1975 Budget Estimate
$1,200,000	Indefinite	$1,200,000

Purpose: Payments are made to the State of Hawaii for care and treatment of persons with Hansen's disease.

Explanation: The appropriated funds are paid as a reimbursement of actual expense to the Department of Health of Hawaii to assist in that care and treatment in its facilities. Any expenses above the appropriated funds are borne by the State of Hawaii.

Accomplishments in 1974: Care will have been provided to an estimated daily average of 143 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $1,880,000, the share borne by Hawaii is $680,000.

Objectives for 1975: The average daily patient load is expected to be 140 in 1975. The total program requirements are estimated to be $1,908,000, of which the Federal government will pay $1,200,000.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Buildings and facilities.

	1974 Amount	1975 Authorization	1975 Budget Estimate Amount
Budget Authority	$14,250,000	Indefinite	$1,300,000
Obligations	12,000,000		5,027,000

Purpose: For construction, alterations, and repairs and improvements of buildings and facilities, including preparation of plans and specifications.

Explanation: Projects anticipated for 1975 require new budget authority; amounts appropriated remain available until expended.

Accomplishments in 1974: In 1974 the obligational authority was directed toward modernization of the PHS hospitals from both a safety and utilization viewpoint. Obligations were incurred as priorities of work were established.

Objectives for 1975: The $1,300,000 requested for 1975 would support nine repair and improvement projects for the Carville, Louisiana Leprosarium and the PHS outpatient clinics.

HEALTH SERVICES ADMINISTRATION

Health services

Program Purpose and Accomplishments

Activity: Program Management (PHS Act, Section 301)

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
893	$33,177,000	Indefinite	903	$35,783,000

Purpose: This activity provides for the overall planning, direction and administration of the Health Services Administration programs.

Explanation: This is a direct operating program which includes salaries and other operating funds to provide management support for the Health Services Administration's programs. The positions supported in this activity are utilized in headquarters to provide national leadership and direction to legislatively mandated programs, and in Regional Offices to provide grant administration and a full range of technical assistance and program guidance to present and potential grantees.

Accomplishments in 1974: (1) Provided management and technical assistance to 54 former OEO neighborhood health centers and networks and 187 family planning projects which were transferred from OEO during 1974. (2) Completed the health services funding regulations and published them in the Federal Register January 9, 1974. These regulations are focused upon improving project management and increasing the level of third-party reimbursements for approximately 800 health services projects. (3) Began the implementation of the health services funding regulations. In this regard, a financial inventory for over 200 of the Bureau's largest projects was completed.

On June 30, 1974, project grant authority for Maternal and Child Health expires and all former project grant funds will be allocated to States under the formula grant provisions of Title V. The title stipulates that services formerly provided under project grants in 1974 will continue to be provided to the same population groups in 1975 and future years. A further requirement is that each State must have a plan which includes "programs of projects" in the five areas. The projects include maternity and infant care, intensive care of newborns, comprehensive care of children and youth, dental health of children and family planning services. In order to fulfill these requirements, Central and Regional staffs will concentrate their efforts on the provision of technical assistance and professional consultation to the States.

In family planning projects, emphasis will continue to be placed on consolidating or coordinating existing grants within States or designated areas to improve the efficiency of services delivery. The integration of family planning services into regular health care settings will continue to be a priority, as will the monitoring of medical care standards.

In migrant health, data collected in the hospitalization demonstration project will be evaluated. This will provide needed information on migrant hospitalization utilization and costs. Limited experimental efforts will be directed to improving service delivery in low impact areas.

The National Health Service Corps will recruit an additional 146 health personnel and provide health care to an additional 55 communities. This will enable 551 health professionals to provide health care to 275 communities. Ten new positions are requested within this activity to augment the Regional Office technical assistance effort. Central Office staff will concentrate on two major activities: recruitment of new health personnel; and general improvement of administration by development of policies, guidelines and procedures that are necessary for the efficient operation of a mature program.

These projects are developing plans for maximizing third-party reimbursements. (4) Completed the development and installation of the ambulatory health care information system and the uniform cost accounting system in nearly 100 neighborhood health centers. These systems will improve decision-making and overall project management. (5) Launched a special demonstration project which involves selected migrant camps to provide hospital care for migrants and itinerant farmworkers and to gather and evaluate data on hospital utilization and cost. (6) Completed a survey and an analysis of selected migrant camps to determine the general nature of sanitary conditions in the camps. Department of Labor was requested to cooperate in the elimination of the causes of identified problems. (7) Provided 405 health professionals to support 220 communities with critical health manpower shortage areas. This is an increase of 72 health professionals and 50 additional communities than were being served as of June 1973. (8) Provide guidance and administrative support toward the implementation of major new program initiatives such as Health Maintenance Organizations, Professional Standards Review Organizations, Emergency Medical Service Systems, and third-party reimbursements.

Objectives in 1975: A major priority will be to continue to improve the financial management capabilities of Bureau projects. Emphasis will be placed on the provision of technical assistance to aid projects in the achievement of third-party reimbursement goals. Special emphasis will be on over 200 projects which were subjected to the intensive site-visit financial inventory approach. The increased collections received from third-party sources may be used to serve a greater number of people residing in target populations.

A substantial effort will be made to improve the quality and efficiency of services delivered in community health centers. In addition to maintaining outside evaluation of the quality of health center services, projects will be assisted in developing, conducting and utilizing their own quality of care assessments.

The Office of the Administrator's principal objectives will be to continue to structure, implement, and oversee major new program initiatives, such as: Health Maintenance Organizations, Professional Standards Review Organizations, Emergency Medical Service Systems, and third-party reimbursements. In addition, the Office of the Administrator will begin to plan toward the eventual interface between the more than 800 health delivery projects and a National Health Insurance Program.

Payments to the General Service Administration for rent will be provided.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services 1/

State	1973 Actual	1974 Estimate	1975 Estimate
Alabama	$1,689,500	$1,676,000	$1,655,300
Alaska	397,600	400,400	402,400
American Samoa	224,911	265,700	265,700
Arizona	952,200	971,600	1,001,200
Arkansas	1,085,900	1,076,400	1,086,900
California	6,753,800	6,816,400	6,813,200
Colorado	1,081,200	1,090,300	1,102,200
Connecticut	1,242,900	1,248,400	1,243,400
Delaware	479,400	478,600	478,300
District of Columbia	516,600	514,400	513,100
Florida	2,767,600	2,803,000	2,882,900
Georgia	2,011,200	2,002,500	2,005,500
Guam	304,000	304,000	319,800
Hawaii	548,600	554,400	561,500
Idaho	572,000	580,000	578,800
Illinois	3,845,200	3,834,900	3,803,500
Indiana	2,113,800	2,102,100	2,091,100
Iowa	1,292,800	1,300,500	1,285,500
Kansas	1,072,000	1,053,600	1,059,800
Kentucky	1,557,500	1,545,000	1,542,500
Louisiana	1,716,600	1,716,700	1,713,600
Maine	672,000	683,500	681,800
Maryland	1,599,400	1,606,200	1,599,200
Massachusetts	2,149,800	2,156,400	2,162,200
Michigan	3,289,500	3,254,200	3,188,200
Minnesota	1,627,100	1,626,000	1,622,900
Mississippi	1,243,200	1,240,400	1,217,100
Missouri	1,950,100	1,936,600	1,915,900
Montana	557,300	557,600	553,400
Nebraska	821,600	818,700	819,700
Nevada	459,000	464,100	471,300
New Hampshire	568,400	569,900	569,900
New Jersey	2,589,400	2,606,500	2,576,700
New Mexico	690,200	701,900	713,700
New York	5,976,200	5,953,000	5,945,100
North Carolina	2,227,000	2,231,200	2,207,600
North Dakota	542,400	529,400	533,100
Ohio	3,919,000	3,908,900	3,849,200
Oklahoma	1,260,400	1,261,600	1,263,600
Oregon	1,049,400	1,049,100	1,056,100

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services[1] (Cont'd.)

State	1973 Actual	1974 Estimate	1975 Estimate
Pennsylvania	$4,310,800	$4,304,600	$4,266,000
Puerto Rico	2,058,500	1,996,300	2,160,700
Rhode Island	624,500	625,200	623,100
South Carolina	1,332,200	1,334,300	1,334,300
South Dakota	552,100	550,200	550,500
Tennessee	1,825,700	1,823,000	1,820,100
Texas	4,380,500	4,427,700	4,458,500
Trust Territory	446,700	440,500	454,800
Utah	710,600	715,300	722,400
Vermont	465,600	465,000	470,100
Virgin Islands	265,700	265,700	265,700
Virginia	1,960,000	1,949,000	1,933,300
Washington	1,454,700	1,457,600	1,441,400
West Virginia	977,400	975,300	968,300
Wisconsin	1,857,500	1,861,900	1,859,000
Wyoming	420,000	418,300	418,900
Total	89,059,211	89,100,000	89,100,000
Evaluation Amount[2]	900,000	900,000	900,000
Grand Total	89,959,211	90,000,000	90,000,000

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[1] Allocations are awarded to States based on population and per capita income with a minimum program requirement.

[2] Authorized by P. L. 91-296.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards [1/]
Fiscal Years 1973-5

States	1973 [2/] Actual	1974 Estimated	1975 [3/] Estimated
Alabama	$1,170,263	$1,220,100	$4,017,300
Alaska	204,191	189,500	323,100
American Samoa	---	147,200	159,900
Arizona	427,684	421,700	1,487,600
Arkansas	711,532	687,000	2,011,600
California	2,910,939	3,141,400	9,169,400
Colorado	489,699	504,100	3,070,900
Connecticut	507,000	497,800	1,675,000
Delaware	216,607	212,600	507,300
District of Columbia	275,171	246,100	3,554,200
Florida	1,659,063	1,581,200	5,542,000
Georgia	1,662,802	1,627,700	4,756,400
Guam	158,600	159,400	231,900
Hawaii	239,667	252,600	968,600
Idaho	254,200	239,500	691,100
Illinois	1,719,924	1,779,600	7,964,700
Indiana	1,273,560	1,345,800	3,911,700
Iowa	723,339	735,300	2,136,500
Kansas	474,873	483,700	1,475,400
Kentucky	1,184,800	1,172,400	3,430,800
Louisiana	1,373,610	1,321,000	3,857,000
Maine	341,200	343,900	998,800
Maryland	1,079,299	1,086,700	5,633,700
Massachusetts	829,533	898,300	4,227,800
Michigan	1,990,200	2,007,100	6,694,800
Minnesota	927,461	940,200	2,869,000
Mississippi	1,081,800	1,041,700	3,051,300
Missouri	1,082,733	1,154,600	3,356,400
Montana	230,755	224,500	610,800
Nebraska	363,321	355,900	1,751,200
Nevada	207,694	205,100	380,900
New Hamphire	232,200	232,200	584,200
New Jersey	1,102,133	1,121,700	3,219,000
New Mexico	342,200	340,800	985,200
New York	2,669,162	2,669,500	13,545,400
North Carolina	1,911,072	1,835,300	5,373,100
North Dakota	220,350	217,700	586,200
Ohio	2,337,224	2,351,400	7,402,400
Oklahoma	627,587	624,600	1,810,700
Oregon	539,104	571,100	1,659,900

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1973-5

States	1973 2/ Actual	1974 Estimated	1975 3/ Estimated
Pennsylvania	$2,605,000	$2,553,700	$7,465,600
Puerto Rico	1,685,200	1,375,700	5,856,000
Rhode Island	252,326	251,000	482,100
South Carolina	1,164,600	1,131,400	3,315,500
South Dakota	230,150	223,100	643,800
Tennessee	1,256,800	1,231,000	3,593,100
Texas	2,606,235	2,646,500	7,659,600
Trust Territory	123,000	164,800	295,500
Utah	423,049	430,100	1,249,100
Vermont	205,572	197,000	492,200
Virgin Islands	157,400	158,200	647,500
Virginia	1,343,300	1,300,400	3,787,000
Washington	832,700	881,300	2,560,000
West Virginia	646,200	603,100	1,760,900
Wisconsin	1,032,757	1,056,000	3,066,700
Wyoming	165,011	183,200	289,700
Total distribution by formula 1/	50,481,852	50,574,500	168,847,500
Special projects for mentally retarded children	4,729,969	4,750,000	4,750,000
Other special projects . . .	5,431,402	5,453,500	5,453,500
Total	60,643,223	60,778,000	179,051,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects is apportioned by formula. Each State receives an amount which varies directly with the number of urban and rural births in the State and inversely with State per capita income. No State receives less than $70,000 and rural live births are given twice the weight of urban births.

(c) The 1974 and 1975 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to some States after they received their notification of allocation of funds.

3/ Included are $25,000,000 in funds distributed under Section 516. These funds are not distributed on the basis of the formula described in 1(a) and (b) above.

HEALTH SERVICES ADMINISTRATION

Maternal and Child Health

Grants to States

State	1974 1/ Supplemental
Alabama	---
Alaska	$24,400
American Samoa	20,800
Arizona	---
Arkansas	74,000
California	15,300
Colorado	---
Connecticut	---
Delaware	75,400
District of Columbia	---
Florida	---
Georgia	208,700
Guam	18,500
Hawaii	---
Idaho	47,100
Illinois	---
Indiana	535,800
Iowa	301,400
Kansas	28,300
Kentucky	402,400
Louisiana	143,500
Maine	144,900
Maryland	---
Massachusetts	---
Michigan	---
Minnesota	22,000
Mississippi	443,300
Missouri	186,500
Montana	23,600
Nebraska	---
Nevada	---
New Hampshire	49,800
New Jersey	343,600
New Mexico	34,300
New York	---
North Carolina	689,000
North Dakota	95,200
Ohio	---
Oklahoma	153,700
Oregon	56,800

HEALTH SERVICES ADMINISTRATION

Maternal and Child Health (Cont'd.)

Grants to States

State	1974 1/ Supplemental
Pennsylvania....................	$184,200
Puerto Rico.....................	---
Rhode Island....................	3,100
South Carolina..................	362,200
South Dakota....................	105,600
Tennessee.......................	416,800
Texas...........................	311,800
Trust Territory.................	44,800
Utah............................	186,500
Vermont.........................	72,000
Virgin Islands..................	---
Virginia........................	221,100
Washington......................	282,900
West Virginia...................	183,100
Wisconsin.......................	459,300
Wyoming.........................	28,300
Total........................	7,600,000

1/ These funds may be used for either maternal and child health services or crippled children's services, at the option of the State. (Section 516, Title V, SSA)

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards [1]
Fiscal Years 1973-5

State	1973 [2] Actual	1974 Estimate	1975 Estimate
Alabama	$1,373,500	$1,331,800	$1,307,500
Alaska	191,500	191,400	192,400
American Samoa	35,200	146,100	146,200
Arizona	536,900	511,600	496,600
Arkansas	695,457	807,700	763,400
California	2,813,100	2,809,200	2,844,900
Colorado	579,000	563,700	548,400
Connecticut	543,800	543,200	542,100
Delaware	219,600	219,400	219,100
District of Columbia	237,842	230,400	229,600
Florida	1,562,629	1,602,100	1,537,200
Georgia	1,686,900	1,656,500	1,596,500
Guam	225,000	154,900	155,100
Hawaii	336,675	252,700	254,200
Idaho	360,547	299,300	290,500
Illinois	1,758,240	1,784,600	1,872,600
Indiana	1,478,000	1,436,900	1,494,600
Iowa	897,416	882,500	889,300
Kansas	599,000	598,500	569,800
Kentucky	1,314,200	1,288,500	1,221,700
Louisiana	1,332,510	1,306,800	1,315,500
Maine	360,400	360,200	379,400
Maryland	846,300	845,800	861,100
Massachusetts	894,878	895,600	982,300
Michigan	2,021,153	1,990,100	2,120,900
Minnesota	1,060,028	1,103,600	1,102,800
Mississippi	1,121,300	1,120,200	1,072,600
Missouri	1,197,700	1,196,900	1,198,100
Montana	286,001	261,100	261,400
Nebraska	453,600	453,300	431,600
Nevada	286,800	211,700	213,100
New Hampshire	251,100	243,900	249,500
New Jersey	1,030,700	1,099,200	1,100,600
New Mexico	494,100	373,900	377,500
New York	2,427,356	2,465,600	2,594,400
North Carolina	2,142,085	2,111,300	2,033,300
North Dakota	271,500	271,400	256,000
Ohio	2,463,100	2,461,500	2,516,700
Oklahoma	754,200	753,700	737,800
Oregon	584,900	584,500	587,500

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1973-5

States	1973 2/ Actual	1974 Estimated	1975 Estimated
Pennsylvania	$2,680,760	$2,675,600	$2,814,400
Puerto Rico	1,570,933	1,570,400	1,484,300
Rhode Island	261,261	261,100	261,300
South Carolina	1,181,700	1,180,600	1,132,500
South Dakota	280,000	274,800	273,600
Tennessee	1,449,297	1,422,200	1,353,300
Texas	2,943,906	2,918,900	2,840,500
Trust Territory	159,800	159,800	160,000
Utah	346,278	346,300	341,100
Vermont	208,871	204,400	204,000
Virgin Islands	150,900	150,900	151,300
Virginia	1,494,300	1,493,000	1,402,500
Washington	790,200	789,900	812,600
West Virginia	741,700	740,900	740,000
Wisconsin	1,239,800	1,238,800	1,313,800
Wyoming	186,462	188,600	188,500
Total distribution by formula 1/	53,410,385	53,037,500	53,037,500
Special projects for mentally retarded children	4,996,045	5,000,000	5,000,000
Other special projects . . .	6,294,498	6,862,500	6,862,500
Total	64,700,928	64,900,000	64,900,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects, is apportioned by formula. Each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than a specific minimum amount and children in rural areas are given twice the weight of those in urban areas.

(c) The 1974 and 1975 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to States after they received their notification of allocation of funds.

New Positions Requested

	1975		
	Grade	Number	Annual Salary
Health maintenance organizations			
Program analyst.........................	GS-15	1	$28,263
Program analyst.........................	GS-14	6	145,482
Program analyst.........................	GS-13	7	144,739
Program analyst.........................	GS-11	1	14,671
Grants clerk............................	GS-9	1	12,167
Secretary...............................	GS-7	3	29,907
Secretary...............................	GS-5	6	48,330
		25	423,559
National Health Service Corps			
Medical Officer.........................	GS-13	35	916,615
Dentist.................................	GS-13	10	206,770
Public Health Advisor...................	GS-13	10	206,770
Nurse Practitioner/Primex Nurse.........	GS-11	35	513,485
Commissioned Officers			
Medical Officer......................	SA	56	806,680
Dental Officer.......................	SA	10	144,050
		156	2,794,370
Total new positions, all activities...................		181	3,217,929

FRIDAY, MARCH 22, 1974.

CENTER FOR DISEASE CONTROL

PREVENTIVE HEALTH SERVICES

WITNESSES

DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL

DR. MARCUS M. KEY, DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL

JAMES H. EAGEN, ACTING EXECUTIVE OFFICER, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

CLAUDE F. PICKELSIMER, FINANCIAL MANAGEMENT OFFICER, CENTER FOR DISEASE CONTROL

WILFORD FORBUSH, DIRECTOR, DIVISION OF BUDGET FORMULATION

PROGRAM AND FINANCING (IN THOUSANDS OF DOLLARS)

	1973 actual	1974 estimate	1975 estimate
Program by activities:			
Direct program:			
1 Disease control:			
(a) Research grants	1, 755		
(b) Project grants	54, 095	59, 550	50, 600
(c) Disease investigations, surveillance and control	42, 095	39, 706	40, 049
(d) Laboratory improvement	8, 351	9, 832	8, 227
(e) Health education	3, 772	3, 206	3, 471
2. Occupational health:			
(a) Grants	3, 906	3, 764	2, 252
(b) Direct operations	21, 212	29, 526	23, 596
3. Buildings and facilities			964
4. Program management:			
(a) Program direction	4, 133	4, 257	7, 319
(b) Regional offices	2, 863	2. 383	2, 300
Total, direct program	142, 182	152, 224	138, 778
Reimbursable program:			
1. Disease control	6, 036	8, 000	8, 000
2. Occupational health	44	330	330
Total, reimbursable program	6, 080	8, 330	8, 330
Total program costs, funded [1]	148, 262	160, 554	147, 108
Change in selected resources (undelivered orders)	970		
Total obligations	149, 232	160, 554	147, 108
Financing:			
Receipts and reimbursements from:			
Federal funds	−5, 828	−7, 699	−7, 699
Non-Federal sources	−252	−631	−631
Unobligated balance available, start of year			−1, 964
Unobligated balance transferred from other accounts		−1, 964	
Unobligated balance available, end of year		1, 964	1, 000
Unobligated balance lapsing	16, 987		
Unobligated balance restored		−15, 982	
Budget authority	160, 139	136, 242	137, 814
Budget authority:			
Appropriation	159, 872	134, 565	137, 814
Transferred to other accounts	−33	−112	
Transferred from other accounts	300		
Appropriation (adjusted)	160, 139	134, 453	137, 814
Proposed transfer for civilian pay raises		1, 789	

See footnotes at end of table.

PROGRAM AND FINANCING CLASSIFICATION (IN THOUSANDS OF DOLLARS)—Continued

	1973 actual	1974 estimate	1975 estimate
Relation of obligations to outlays:			
Obligations incurred, net	143, 152	152, 224	138, 778
Obligated balance, start of year	84, 016	84, 954	70, 030
Obligated balance transferred net		897	
Obligated balance, end of year	−84, 954	−70, 030	−73, 637
Adjustments in expired accounts	−5, 986		
Outlays, excluding pay raise supplemental	136, 229	166, 308	135, 119
Outlays from civilian pay raise supplemental		1, 737	52

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[1] Includes capital outlay as follows: 1973, $2,370,000; 1974, $2.129,000; 1975, $2,129,000.

Note.—Excludes $35,000 in 1975 for activities transferred to: salaries and expenses Office of Assistant Secretary for Health. Comparable amounts for 1973, $35,000; 1974, $35,000 are included above. Also excludes $14,000 in 1975 for activities transferred to mental health. Comparable amounts for 1973, $14,000; 1974, $14,000 are included above.

OBJECT CLASSIFICATION (IN THOUSANDS OF DOLLARS)

	1973 actual	1974 estimate	1975 estimate
Direct obligations:			
Personnel compensation:			
Permanent positions	49, 481	48, 322	49, 455
Positions other than permanent	618	1, 078	1, 078
Other personnel compensation	1, 101	1, 192	1, 192
Total personnel compensation	[1]51, 200	50, 592	51, 725
Personnel benefits: Civilian	6, 604	5, 652	5, 733
Benefits for former personnel	37	72	
Travel and transportation of persons	3, 164	3, 513	3, 513
Transportation of things	624	733	733
Rent, communications, and utilities	3, 482	3, 694	6, 940
Printing and reproduction	722	914	997
Other services	15, 400	35, 282	17, 390
Supplies and materials	4, 165	4, 184	4, 159
Equipment	2, 370	2, 129	2, 129
Lands and structures	118	8	8
Grants, subsidies, and contributions	55, 260	45, 453	45, 453
Insurance claims and indemnities	7		
Subtotal	143, 153	152, 226	138, 780
Quarters and subsistence charges	−1	−2	−2
Total direct obligations	143, 152	152, 224	138, 778
Reimbursable obligations:			
Personnel compensation:			
Permanent positions	3, 559	2, 079	2, 079
Positions other than permanent	24	20	20
Other personnel compensation	94	40	40
Total personnel compensation	3, 677	2, 139	2, 139
Personnel benefits: Civilian	389	192	192
Travel and transportation of persons	281	802	802
Transportation of things	83	233	233
Rent, communications, and utilities	151	349	349
Printing and reproduction	24	68	68
Other services	695	2, 735	2, 735
Supplies and materials	619	1, 339	1, 339
Equipment	161	473	473
Total reimbursable obligations	6, 080	8, 330	8, 330
Total obligations	149, 232	160, 554	147, 108

PERSONNEL SUMMARY

Total number of permanent positions	4, 272	3, 599	3, 656
Full-time equivalent of other positions	103	154	154
Average paid employment	4, 330	3, 707	3, 749
Average GS grade	8. 7	8. 9	9. 3
Average GS salary	$13, 869	$14, 474	$14, 990
Average salary of ungraded positions	$9, 824	$9, 770	$9, 770

Mr. FLOOD. The committee will come to order.

We will hear the Preventive Health Services.

The presentation will be made by Dr. David J. Sencer, Director for the Center for Disease Control. The biographical sketch that we have, Doctor, we will insert in the record at this point.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, CENTER FOR DISEASE CONTROL

(BIOGRAPHICAL SKETCH)

Name: David J. Sencer, M.D.

Position: Director, Center for Disease Control.

Birthplace and date: Grand Rapids, Mich., November 10, 1924.

Education: Wesleyan University, Middletown, Conn., 1944; University of Mississippi, 1946; University of Michigan, 1951, M.D.; University Hospital, Ann Arbor, Mich., 1951, internship; internal medicine residency, 1954; and Harvard University School of Public Health, 1958, M.P.H., magna cum laude.

Experience:

Present: Director, Center for Disease Control, Atlanta, Ga.
January 1973–May 1973: Acting Administrator, Health Services and Mental Health Administration.
1964–66: Deputy Chief, Center for Disease Control, Atlanta, Ga.
1960–64: Assistant Chief, Communicable Disease Center, U.S. Public Health Service, Atlanta, Ga.
1959–60: Program Officer, Bureau of State Services, U.S. Public Health Service, Washington, D.C.
1955–59: Medical Officer in Charge, Muscogee County TB Field Research Facility, DSPBS, Columbus, Ga.
1955: Medical Consultant, Tuberculosis Program, U.S. Public Health Service.

Teaching appointments: Visiting lecturer on tropical public health, Harvard University School of Public Health, Boston, Mass.; clinical professor of preventative medicine, Emory University School of Medicine, Atlanta, Ga.

Association memberships: American Medical Association; American Public Health Association; American Thoracic Society; American Society of Tropical Medicine and Hygiene; Delta Omega; Georgia Tuberculosis Association; International Epidemiological Association; diplomat with American Board of Preventive Medicine; and fellow with American College of Preventive Medicine.

Scientific publications:

Comstock, G. W., Keltz, H., and Sencer, D. J., "'Clay eating and sarcoidosis," a controlled study on the State of Georgia. Am. Rev. Resp. Dis. 84: 130–134, 1961.
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Mosley, J. W., and Sencer, D. J., "Isoniazid toxicity." JAMA 218: 447, 1971.
Sencer, David J., and Rubin, Robert J., "Risk as the basis for immunization policy in the United States," prepared for delivery at Symposium on Influenza Vaccines for Men and Horses, November 1972, London, England.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, PUBLIC HEALTH SERVICE, CENTER FOR DISEASE CONTROL, PREVENTIVE HEALTH SERVICES

Mr. Chairman, you have before you the 1975 budget for Preventive Health Services which requests $137,814,000 for 1975. This budget will enable the Center for Disease Control to press ahead with programs and activities designed to improve the health of the people of the United States by preventing or controlling diseases, improving laboratory performance, and assuring safe and healthful working conditions for the Nation's work force. In working toward these ends, the Center undertakes a full range of activities including research, technical and financial assistance, standard setting, and, in some instances, regulation. The document emphasizes the accomplishments we anticipate if our appropriation request is approved. I would like to take this opportunity to give an accounting which highlights what we will achieve this year; providing, hopefully, a more complete picture of where we are now in relation to where we hope to be next year.

DISEASE CONTROL—VENEREAL DISEASES

I can report that the expanded venereal disease control campaign which we started in late 1972 is showing demonstrable progress. Continued pressure on the venereal disease problem has had results in both infectious syphilis and gonorrhea. During the first 6 months of 1974, infectious syphilis declined by 2.4 percent—the first such decline since 1969. This represents significant improvement since infectious syphilis actually increased at a faster rate during 1973, the first full year of the intensified national program. Because these improvements began during the second half of 1973 and have accelerated so far this year, we are projecting a 5 percent decline in infectious syphilis next fiscal year (1975).

Although gonorrhea remains on the increase in the United States at the present time, the changes in incidence have been in some ways more impressive than the record against syphillis. The average annual rate of increase in reported gonorrhea has been approximately 15 percent over the past 5 years with an increase of 12.7 percent recorded in 1973. During 1973 the first year of the program, approximately 5 million screening tests for gonorrhea were provided to women which resulted in the diagnosis and treatment of almost a quarter of a million infections. As would be expected, the number of females diagnosed with gonorrhea during 1973 increased by more than 36 percent over 1972. Male cases increased by only 2 percent which is the lowest annual rate of increase recorded in the past decade. However, during the first 6 months of this year, reported cases of gonorrhea have increased by only 6.2 percent compared with the same period of a year ago. Even more significant is the fact that during the second quarter, male cases actually decreased 3 percent and the rate of increase for female cases dropped to only 15 percent. All of this has occurred at the same time that screening activities were expanded to the point where some 600,000 tests were being performed per month. These trends lead us to predict that the increase in gonorrhea will be halted next year.

DISEASE CONTROL—IMMUNIZATION

In our budget justification, we have expressed the progress of our immunization programs in terms of anticipated increases in the levels of protection against measles, rubella, and polio. This approach gives you a good measure of how our programs are doing, but it does not tell you what is happening with the diseases. For example, in 1971 project grant support for the measles control program was reinitiated when the number of reported cases of measles jumped to more than 75,000. By 1973, the number of cases dropped to less than 27,000 and so far this year we have seen an additional 33 percent decline when compared with the same period in 1973.

The track record against rubella parallels the measles experience. More than 56,000 cases of rubella were reported in 1970; less than 28,000 in 1973. Reports this year indicate a decrease of 49 percent compared to the same period in 1973.

Disease incidence is down, but our job is far from over. Indeed, our job will be harder as we zero in on specific problem areas.

DISEASE CONTROL—ENVIRONMENTAL HEALTH HAZARDS

Many families in our Nation's urban areas are sharing living space with large rat populations. While the rat problem is a symptom of broader problems of urban decay, there are public health control measures that can be undertaken. The urban rat control grant program was begun in 1969 and is now serving seven million target area residents in 59 communities. The goal of these projects is to reduce rat infestations to a maintenance level which will permit a less costly, locally supported program operation. By the end of 1974, we will have reached the maintenance level in 50 percent of the target areas and will increase this to 60 percent by the end of next fiscal year.

Another environmental health problem, especially in our urban areas, is the result of the fact that many children live in dilapidated housing which is likely to contain lead-based paint. It is estimated that 600,000 children actually ingest enough paint to have elevated blood lead levels. All of these children are at risk of developing illnesses which vary from mild symptoms to severe mental retardation and death. Although the long-term solution to the problem is to eliminate lead-based paint from all dwelling units, the immediate problem of preventing unnecessary illness and suffering must be continued. Until the housing problem is solved, public health efforts must be concentrated in screening activities to identify those children who have elevated blood levels. One of the major obstacles to the continued success of the screening program is the inadequate number of laboratories capable of performing blood lead analyses. Therefore, in 1974, using 1973 restored funds, we will be making grants to State laboratories to enable them to develop the necessary competence in this area. Solution to the public health problems of lead-oased paint poisoning depends upon such a strengthening of State public health laboratories.

DISEASE CONTROL—INVESTIGATIONS, SURVEILLANCE, AND EPIDEMIC AID

When the Center's disease investigations, surveillance, and control activities are mentioned, many people think of our epidemic intelligence service. This highly trained corps of epidemiologists, or "disease detectives," respond to disease outbreaks throughout the country, or overseas, on a moment's notice. In 1974, we estimate that they will have been involved in over 1,200 disease investigations. Less glamorous perhaps but just as vital are the longer term studies that may yield new disease control information, new prevention techniques, or new diagnostic tests. In addition, disease prevention and control efforts rely heavily upon the maintenance of an effective surveillance system which provides current intelligence on disease developments. Since the budget document gives a good idea of the scope and depth of these activities, I will mention just a few episodes which serve to illustrate our approach to solving disease problems. Last summer a large outbreak of gastroenteritis was reported aboard a cruise ship operating in the Caribbean. Most of the 700 passengers and more than half the crew of 300 were stricken. A team of physicians and laboratorians were dispatched from the Center to meet the ship on its arrival. The problems was identified as stemming from inadequate chlorination of the ship's water supply. After corrective measures were taken, the vessel was able to resume operations. The incident triggered a general investigation of health and sanitation aboard cruise ships. In mid-February, there was a meeting in Atlanta with representatives from the cruise ship lines to discuss ways to prevent such outbreaks.

Another example can serve to illustrate the value of an effective surveillance system. In the first 11 months of 1973, only five cases of *salmonella eastbourne* were reported to CDC. But in December and January, 44 cases were reported from 11 States. Preliminary investigation implicated Christmas candy as the source of infection. Joint investigations carried out by State and local health departments, the Food and Drug Administration, and CDC confirmed the early findings and identified the specific product in question. On February 1, FDA announced the voluntary recall of the chocolate candy by the manufacturer.

There is one area where we feel we have fallen short and that is in the prevention of hospital infections. Improved, rapid reporting of hospitally acquired infections is a prerequisite. But in many cases, an outbreak has come and gone before we are aware of it. While retrospective investigations add to our knowledge, we are not able to apply our knowledge in preventing illnesses. To prevent hospital infections will require changes in the thousands of hospitals across the Nation. To bring about changes in hospital procedures in the face of rising hospital costs, we must be able to demonstrate that preventive measures will work and will have an economic payoff. In 1975, 10 additional positions have been requested for this purpose.

DISEASE CONTROL—LABORATORY IMPROVEMENT

The passage, in 1967, of the Clinical Laboratory Improvement Act (CLIA) marked a significant step forward for the Center's laboratory improvement activities. Laboratory quality standards under medicare and FDA regulation of certain diagnostic products have added dimensions to the Department's impact on clinical laboratory performance. In 1974, another milestone was reached. Under an agreement between CDC, the Health Services Administration, and the Social Security Administration, the Center is developing common technical laboratory standards that will be applied to more than half the Nation's estimated 12,000 clinical laboratories. In addition to extending the coverage of the laboratory improvement program, we are continually evaluating its effectiveness. For example, a recent study indicates that normal laboratory performance may be below the levels reflected in the proficiency testing we do as a part of the licensure program. If further analysis verifies these early findings, it will be necessary to revise our approach to the monitoring of the quality of laboratory performance. To carry out this expanded program, we are requesting 10 additional positions in 1975.

DISEASE CONTROL—HEALTH EDUCATION

In 1975, CDC will undertake an important new initiative designed to provide leadership and coordination of health education activities which have been lacking across the range of Federal health programs and the private sector as well. In doing so, we plan to build upon and expand the promising educational programs already underway in the Center's National Clearinghouse for Smoking and Health. We shall be working closely with voluntary and professional associations in helping to launch the private-sector-based National Center for Health Education which was called for in the President's special health message to the Congress. At the same time, working with and through a special interagency health education committee, we hope to bring together major educational efforts of many Federal agencies so that they will reenforce each other, rather than compete for public time and attention.

OCCUPATIONAL SAFETY AND HEALTH

The impact of occupational injuries and disease is staggering. Over 14,000 deaths occur each year from job-related injuries, and we estimate that up to 100,000 deaths can be attributed ot occupational disease. Workmen's compensation costs alone average $2.3 billion per year. Working through the Center's National Institute for Occupational Safety and Health, our Department complements the activities of the Department of Labor whose prime function in this area is to set and enforce occupational safety and health standards. In other words, we develop safety and health criteria which are used by the Department of Labor to set safety and health standards. Under the Federal Coal Mine Health and Safety Act, we are responsible for promulgating health standards and conducting research on health problems of coal miners, while the Department of Interior is charged with the safety responsibilities.

The development of occupational health criteria is a process which may take many years depending upon the extent of our knowledge about a given occupational disease or hazard. Therefore, the selection of research areas is of critical importance. This fall, formalized joint program planning between NIOSH and the Occupational Safety and Health Administration was instituted. While both organizations would benefit, we expect a sharpening of our research objectives so that we can better plan the research which should be undertaken in-house and that which should be supported by contract. To support and extend the impact of its research activities, NIOSH conducts surveillance of occupational illnesses and accidents, provides training, carries out industrywide studies, and responds to requests from employers and employees for health hazard evaluation.

In 1974, NIOSH personnel responded to some 200 requests for health hazard evaluations. One such request relating to a plant engaged in vinyl chloride polymerization uncovered an unusually high number of cases of angiosarcoma of the liver among the workers. This is an exceedingly rare tumor. The clustering of cases among a small number of workers at a single plant is a most unusual event and raises the possibility of some work-related carcinogen, and the possibility that the problem may be industrywide. Epidemiologic studies are now underway to determine the extent of the problem in the United States. For 1975, we have requested an additional 40 positions in order to strengthen our in-house research capabilities.

Mr. Chairman, I will be happy to answer any questions that you or other members of the committee may have.

Mr. FLOOD. Do you have someone with you that you want us to know?

Dr. SENCER. Yes. Dr. Marcus M. Key, the Director, National Institute for Occupational Safety and Health; Mr. James D. Bloom, Executive Officer, Center for Disease Control, on my left; and Mr. Claude F. Pickelsimer, Jr., financial management officer of the Center for Disease Control.

Mr. FLOOD. I see you have a prepared statement here which we have examined at some length, so we will question you and see how your answers are this morning. The statement will be inserted in the record following your biographical sketch.

PROGRAMS SUPPORTED

This appropriation, of course, supports several activities, such as disease control, infectious diseases, rat control, lead-based paint poisoning, laboratory improvements, and occupational safety and health.

VENEREAL DISEASE

On this matter of venereal disease, take a look at page 110 of your justifications. There is stated: "Venereal diseases are epidemic in the United States."

We have been listening to that for several years. I believe that is exactly what you told us last year. If it is true, why are you requesting exactly the same funding in 1975 that you had available in 1974?

Dr. SENCER. We are requesting the same funding level, Mr. Chairman, because we are through with our startup phase of the program, and are now actively engaged in all project areas. I think if you will notice in our opening statement that we do point out that while it is epidemic, we are beginning to see some signs of improvement. Actually, infectious syphilis in the first 6 months of this fiscal year has declined. This is the first time since 1969 that we have seen a decline in the rate of infectious syphilis in this country. We attribute that to the fact that there has been an increased effort in the area of gonorrhea as well as of syphilis, and we think that by treating the many cases of gonorrhea now, we are preventing syphilis from occurring. The incubation period for syphilis is considerably longer than for gonorrhea, so that if an individual has contracted the two diseases simultaneously, by treating his gonorrhea we have also treated syphilis before it has made its clinical appearance.

Mr. FLOOD. Are you doing enough to inform the public?

Dr. SENCER. Yes. We have been making a concerted effort both with the medical profession and the public in the past year. We have been publishing in a variety of journals, information on the severity of gonorrhea if it is untreated, particularly in women. We estimate that the amount of gonorrhea that we have treated in asymptomatic women this past year has prevented about $60 million worth of hosptialization for the treatment of pelvic inflammatory disease in women. This year we have undertaken, with the JC's, an intensive nationwide program to inform the public through local means.

Mr. FLOOD. I have seen a good deal of publicity about that. That is very good.

Dr. SENCER. Yes. We also have a nationwide program now called Operation Venus, which is funded by the Public Health Service but operated by a teenage group in Philadelphia. I think I have mentioned this before. We have now gone nationwide with this program where any teenager who is concerned about venereal disease, can call Philadelphia not on an open line but on a free telephone line, and get information about what he should do in his local community.

Mr. FLOOD. I remember discussing this a couple of years ago. What are you doing with public education concerning the misunderstanding about catching V.D. from toilet seats, the faucet in the bathroom, and all these kinds of things. You remember the long list, all those talks and ideas, whatever they were. Are you still with those things, do you just blush those off, or what?

Dr. SENCER. I think the public has become considerably more sophisticated in terms of what can be said and how it can be said in public about diseases that are sexually transmitted. In areas where venereal disease is particularly prevalent, in the inner city areas, in society groups who have different life styles, there have been a number of imaginative——

Mr. FLOOD. Society groups?

Dr. SENCER. I am thinking of some of the hippie communes, the people who have different life styles, where we do find higher rates of venereal disease. There have been many imaginative approaches to publicizing the true nature of venereal disease, the true nature of its transmission.

Mr. FLOOD. Mrs. Green couldn't be present here this morning. She had a prior commitment. She asked me to address this question to you.

Last year we had a discussion of the reasons why you were proposing to screen only women and not men for gonorrhea. I believe your answer was that women may have this disease without any apparent symptoms, but that men who have it are likely to have painful symptoms and to seek medical care. Are you aware of the studies which were recently reported in the newspapers, which found that many men carry gonorrhea without knowing it because they have no symptoms? Would these findings cause you to change your policy with respect to screening of men as well as of women for venereal diseases, especially gonorrhea?

Dr. SENCER. Yes, sir.

Mr. FLOOD. I want to insert in the record at this point an article from the Los Angeles Times of March 3, 1974 entitled "Symptomless VD in Men Reported" as well as another article from the New York Times of January 20, 1974, "Some Gonorrhea Lacks Signs."

[The information follows:]

[From the New York Times, Jan. 20, 1974]

SOME GONORRHEA IN MEN LACKS SIGN

STUDY FINDS MORE UNKNOWN CARRIERS THAN SUSPECTED

(By Lawrence K. Altman)

A team of University of Washington doctors has found from a study of civilians and soldiers that many more men than previously believed are unknown carriers of gonorrhea. Public health officials say that this venereal disease has reached epidemic proportion in many countries.

In a report of this week's issue of The New England Journal of Medicine, the Seattle doctors said that "a major factor in the current gonorrhea pandemic is the failure of physicians to identify and treat" symptomless male carriers of the bacterium that causes gonorrhea. New York City venereal disease experts have found similar results from an unpublished pilot study.

The culture test used to detect gonorrhea is generally not part of a routine medical examination.

Findings from such studies have led epidemiologists to develop the concept that the symptomless man or woman is just as important as the person with clinical symptoms in spreading gonorrhea to a sex partner—in whom symptoms may or may not develop.

Question of mass tests

Accordingly, the U.S. Public Health Service has recommended that physicians pay more attention to treating sexual partners of gonorrhea patients.

Also, the findings have raised the question among public health doctors whether costs of mass screening tests to detect symptomless male gonorrhea carriers would be worth the benefits of reducing the impact of the disease. Complications of gonorrhea can be so serious as to produce kidney failure, arthritis, sterility, heart damage and even meningitis. Most, but not all, such complications follow symptomatic gonorrhea.

Because most previous studies have shown that only a small proportion of male contacts of women with gonorrhea have symptomless infections, the Seattle doctors said that "the main thrust of current efforts to control gonorrhea is the identification of" symptomless female carriers by encouraging doctors to do screening tests for gonorrhea.

More testing urged

Doctors should test more men and women for gonorrhea, the Seattle team—Dr. H. Hunter Handsfield, Dr. Timothy O. Lipman, Dr. James P. Harnisch, Evelyn Tronca, and Dr. King J. Holmes—said on the basis of its findings.

As one part of their study, these doctors detected gonorrhea in 40 percent of symptomless male contacts of women with gonorrhea who had been treated at Seattle-King County veneral disease clinics.

To be certain that they had detected symptomless carriers and not patients incubating clinical infections, the doctors asked 28 such patients to refrain from accepting therapy so the natural course of these infections could be documented. The patients voluntarily agreed to do so for periods ranging from 7 to 165 days. Of the 28 volunteers, 18 remained symptomless. Then the patients were treated.

Study of soldiers

This phase of the study led the doctors to conclude that such infections tend to persist and to remain without symptoms, and that cultures taken from the front part of the urethera (the tube through which urine passes out the penis) are the best method of detection.

The doctors then studied 2,628 sexually active soldiers undergoing routine physical examinations at Madigan Army Medical Center in Tacoma and found that 59, or 2.2 percent had gonorrhea. Of these, 68 percent were symptomless infections. The investigators also documented that some of these men who harbored symptomless gonorrhea infections had spread symptom-causing infections in women.

The doctors said that the previous failure to recognize the importance of symptomless infections in men had led to two misconceptions.

The first is that gonorrhea is almost always symptomless in the female and symptomatic in the male. The infection can by symptomatic or symptomless in either sex, the doctors stressed.

The second misconception is that men get gonorrhea from women with chronic symptomless infections but that women get gonorrhea from men with incubating or symptomatic infections. Although seldom verbalized, this misconception has served as a basis for public health practices and has led to an attitude that it is futile to trace male sexual contacts of women with gonorrhea, because the male will develop symptoms and seek treatment.

Dr. Vernal Cave of the New York City Health Department argeed in a telephone interview that symptomless infections in men "were more of a problem than originally believed." He said that the department was undertaking a study designed to help reduce the impact from symptomless gonorrhea infections.

[From the Los Angeles Times, Mar. 3, 1974]

SYMPTOMLESS VD IN MEN REPORTED

(By Harry Nelson)

SAN FRANCISCO.—After many years of believing that only females can be symptomless carriers of gonorrhea, doctors now have learned that males also can be unknowing carriers.

Dr. King K. Holmes of the University of Washington told the California Medical Association meeting here that about two-thirds of all males in the community with gonorrhea have no symptoms.

Venereal disease authorities have said that males almost always have symptoms which alert them to seek treatment.

Females, they have said, sometimes have symptoms, but often do not. This reservoir of undetected and untreated females is seen as part of the reason it has been so hard to wipe out gonorrhea.

The discovery by the University of Washington team that males can have the disease without symptoms has important implications in venereal disease control.

Holmes said one implication is for women who voluntarily go to private physicians for treatment because they have symptoms.

Sixty percent of these self-referred women are infected by males who had no symptoms, he said.

Treating these women is not effective, he said, because they probably will become reinfected by the same symptomless males.

Untreated gonorrhea is a major cause of infertility in females because of the scarring action it causes in fallopian tubes. It is also associated with some forms of arthritis.

Dr. SENCER. Yes, sir, we are very familiar with those studies since we either support them or did them ourselves. In one study of men in venereal disease clinics who had no symptoms we found 11 percent of these men to be positive on culture. In another group of men who had no symptoms but who had been named as a sexual partner of women with gonorrhea it was as high as 50 percent, so we are adjusting our policies to include screening of asymptomatic men who appear in situations such as venereal disease clinics or who are named as contacts.

RAT CONTROL PROGRAMS

Mr. FLOOD. How about rat control? How much of the cost of the ongoing rat control projects are the local governments picking up?

Dr. SENCER. The guidelines are that the local government—did you say rats, or lead, sir?

Mr. FLOOD. Rat control projects.

Dr. SENCER. At the present time 49 percent of the costs of the rat control program are being paid by local support. When the program was initiated in 1969, it was only around 27 percent, so we have doubled the amount of local support going into the rodent control program.

Mr. FLOOD. Do you find that amount increasing?

Dr. SENCER. It is getting difficult to get it increased more. Last year it was 45, this year it is 49 percent.

Mr. FLOOD. In my district last Friday I went to a luncheon of the first anniversary of the vector control program. I asked him how are you doing on your rats. This is apparently pretty well received.

Dr. SENCER. Yes.

Mr. FLOOD. Because instead of being in the inner city of the large cities, this was in the area there which, of course, is not a large city. It was spreading out through the areas. They indicated the purpose and intent of the program is to reach out beyond the inner-city area, the large city area. They have an operation in Pittsburgh, of course, and in Philadelphia and so on in region 3, and in Baltimore, Md., and Norfolk, but here is an operation going on for years very successfully in what is not a large city area. What are you doing about that? Are you spreading this out?

Dr. SENCER. As we get more and more of the programs into the maintenance phase, where the Federal dollar is not as important, we are trying to get out into some of the areas where rats are a problem that is not quite as dramatic as in the inner cities of New York and Chicago. We do have programs in several of the smaller communities in upstate New York, and actually we have been able to get the Federal Government disengaged.

Mr. FLOOD. As a result of this local government funding, will you be able to initiate new projects in 1975 with this budget?

Dr. SENCER. Yes, we anticipate new projects. I think seven new projects will be initiated.

Mr. FLOOD. Will the local governments eventually pick up the cost of these?

Dr. SENCER. We feel that this is essential. This is built into the regulations that we have promulgated for the rodent control program. As I say, in upstate New York, two cities have been able to pick it up so far. The initial intent of the program was for 5 years of Federal support; we feel that in some instances we may have to go as far as 7.

Mr. FLOOD. What cities?

Dr. SENCER. Binghamton was one of them, and I will have to give for the record the others.

[The information follows:]

Names of cities that have picked up total cost of rat control projects: Binghamton, N.Y., and Poughkeepsie, N.Y.

Mr. FLOOD. What is the total number of rat control projects funded in 1974? Will you insert in the record where these projects are located?

Dr. Spencer. Yes. We have projects in 59 communities. We will insert it for the record.

Mr. FLOOD. And where you expect to have new ones in 1975.

[The information follows:]

FISCAL YEARS 1974 AND 1975

Grant funds are increasingly used to initiate new rat control projects with shorter time frames for reaching a maintenance level of control. During fiscal year 1975, funds will be available to support approximately seven new projects. It is anticipated that, in addition to those communities which have already applied for funds but have not received support, other communities will request rat control funds. Since grants are awardel on the basis of merit of proposed projects and available funds, the exact location of communities to be funded will not be known until some time in fiscal year 1975. A list of existing grants, and the communities which they serve, follows:

Grantees (34) and communities (59)

1. State of Arkansas:
    - (*a*) Little Rock.
    - (*b*) Pine Bluff.
    - (*c*) Hot Springs.
    - (*d*) Burdette.
2. San Francisco Bay Area Health Association:
    - (*a*) East Palo Alto.
    - (*b*) Richmond.
3. San Francisco, Calif.
4. Economic Opportunity, Inc., Atlanta, Ga.
5. Chicago, Ill.
6. Indianapolis, Ind.
7. Fort Wayne, Ind.
8. Kansas City, Kans.
9. New Orleans, La.
10. Baltimore, Md.
11. Worcester, Mass.
12. Flint, Mich.
13. Kansas City, Mo.
14. St. Louis, Mo.
15. State of New Jersey:
    - (*a*) Camden.
    - (*b*) Hoboken.
    - (*c*) Jersey City.
    - (*d*) Newark.
    - (*e*) Paterson.
    - (*f*) Plainfield.
    - (*g*) Trenton.
16. State of New Mexico:
    - (*a*) Tucumcari
    - (*b*) Albuquerque
    - (*c*) Clovis.
    - (*d*) Las Cruces.

16. State of New Mexico—Continued
    - (*e*) Raton.
    - (*f*) Alamagordo.
17. State of New York:
    - (a) Binghamton.
    - (b) Buffalo.
    - (c) New York City.
    - (d) Poughkeepsie.
    - (e) Rochester.
    - (f) Syracuse.
    - (g) Cohoes.
18. Charlotte, N.C.
19. Cleveland, Ohio.
20. Tulsa, Okla.
21. Chester, Pa.
22. Northeast Pennsylvania Vector Control Association:
    - (a) Hazelton City.
    - (b) Wilkes-Barre City.
    - (c) Scranton.
    - (d) Luzerne County.
    - (e) Nanticoke City.
    - (f) Lackawana County.
23. Philadelphia, Pa.
24. Allegheny County (Pittsburgh, Pa.).
25. York, Pa.
26. Nashville, Tenn.
27. Memphis, Tenn.
28. Houston, Tex.
29. Norfolk, Va.
30. Seattle, Wash.
31. Milwaukee, Wis.
32. War on Rats, Washington, D.C.
33. Youth Pride, Inc., Washington, D.C.
34. San Juan, P.R.

LEAD-BASED PAINT

Mr. Flood. On lead-based paint, your budget request this year for lead-based paint is the same level as last year. You also state there are 2.5 million children in the United States who are at risk. How many of these 2.5 million children will you be able to screen with this budget?

Dr. Sencer. So far, sir, we have screened over 25 percent of the children at risk since the program was started. Actually this year there will be an additional expenditure because of some one-time money that will allow us to get all of the State health department laboratories in a position where they can provide screening. We are looking at ways in which the screening process can become cheaper. There are tests available that are being evaluated at the present time which may be a more sensitive index of exposure to lead, but at considerably less cost.

Also this past year the title 19 program of early childhood screening has incorporated into it provisions for screening for lead-based paint, that without additional expenditures in this account, we feel that we will be reaching more children.

Mr. FLOOD. Do any of the other service programs, the neighborhood health centers, the maternal and child health centers, family health centers and so on perform the routine screening on this population to detect elevated blood levels?

Dr. SENCER. We have not encouraged too much of this to date, Mr. Chairman, because of the unavailability of laboratory services——

Mr. FLOOD. You say you do not?

Dr. SENCER. We have not, no, sir.

Mr. FLOOD. Why not? Don't they have the capability to peform these tests?

Dr. SENCER. No. This is a very difficult test to perform. It takes very expensive equipment, and until we get the State health departments in a position where they can provide this testing on a centralized basis, we have not been encouraging too much activity outside of those areas which we specifically support.

Mr. FLOOD. You state in your budget justifications for the lead-based program that emphasis will be on developing the necessary laboratory competence in blood lead analysis in the States, and the communities. How are you going to go about that?

Dr. SENCER. We do have funds available this year to provide a grant to each State health department that will gear it up with equipment and with trained personnel to provide these services.

Mr. FLOOD. We have talked about this lead-based thing for several years, and how tough it is and how hard it is to conduct these tests. Is anybody taking a look at that? Has anyone been able to develop an inexpensive test for detecting lead in blood?

Dr. SENCER. Yes, sir. We are evaluating this year, as I mentioned, a new test that has been developed that is considerably more sensitive and easy to perform and may reduce the cost by over 50 percent.

LABORATORY IMPROVEMENT PROGRAM

Mr. FLOOD. I would hope so. On laboratory improvement, that is on page 118 of your budget justifications, you state that the standards as defined in the Clinical Laboratories Improvement Act will be applied to an estimated 1,150 laboratories. How many laboratories across the country are covered by the act?

Dr. SENCER. Currently there are around 1,200 laboratories covered by the act. This is out of a universe of 14,000 laboratories of which 7,000 are in hospitals that are covered by medicare regulations.

Mr. FLOOD. When do you expect to have all these laboratories tested, as required by the act?

Dr. SENCER. These are the laboratories that are required by the act, sir. The other laboratories are laboratories that do not provide services in interstate commerce. Our concern is that we need to extend similar coverage, not necessarily through additional legislation but by utilizing the medicare certification to extend the types of services that are provided to laboratories in interstate commerce to all laboratories that we can reach.

Mr. FLOOD. What about capability? Does the capability for doing more in terms of laboratory improvement exist today?

Dr. SENCER. Yes. The capability exists if you combine the efforts of the Federal Government and the State governments. We are currently working with the Bureau of Quality Assurance, and the Bureau of Health Insurance, in the Social Security Administration, to link the two programs so that we have common high standards of laboratory services in all independent laboratories.

Mr. FLOOD. How do you characterize the proficiency level of the labs that you have tested say in the past year?

Dr. SENCER. We have demonstrated that is improving in most of the fields. We do have some areas of considerable concern, and we are looking into these.

One of the areas is that we know when a laboratory gets a proficiency testing specimen, to find out how good it is, it puts its best technician to work on that specimen. What we are measuring in the interstate laboratory program is the best level of effort.

Mr. FLOOD. You talk about the States. What role do the State health departments play in your laboratory improvement program?

Dr. SENCER. State health departments are the backbone of the laboratory improvement program. As I say, we can only reach a limited number of laboratories, and we work with the States so that they in turn can put on training courses for laboratories within their States, can do proficiency testing for laboratories within their States. We are working to provide them an inspection manual so that we are performing inspections in a similar manner at a high standard throughout the country.

Mr. FLOOD. By the way, do these laboratories pay you for conducting these proficiency tests?

Dr. SENCER. No, sir. The laboratories that are in interstate commerce pay a licensing fee, but the proficiency testing is done on a voluntary basis with no charge.

COMMERCIAL PACKAGED REAGENTS

Mr. FLOOD. Again in your justifications you state that you are testing commercial packaged reagents. Do you do this routinely, and do you do it prior to the item being marketed?

Dr. SENCER. For a few reagents we have a complete premarket clearance. A case in point is the serum that is used to diagnose rubella (German measles). We feel that much of the serologic testing for German measles is being done in women who are pregnant to make a determination whether she may have contracted the disease in the early stages of pregnancy. This may lead to a deformed baby, and we feel that this is a sensitive enough issue that all material that goes on the market should be tested.

In other areas, we are working with the Food and Drug Administration; we develop the scientific criteria for evaluating the products, and then they enforce them.

Mr. FLOOD. How many new commercial package reagents come on the market each year?

Dr. SENCER. I will have to supply that for the record, sir. It is an astounding number. It is a burgeoning industry, and one which truly is frightening in some respects, because any physician can buy one of these packaged diagnostic tests and do it in his office with untrained personnel. We are working very closely with the Food and Drug Administration to control the quality of the reagents that are put into these kits.

[The information follows:]

NUMBER OF NEW COMMERCIAL PACKAGE REAGENTS COMING ON THE MARKET EACH YEAR

We will not be able to derive an accurate answer to this question until after the Food and Drug Administration labeling requirements for in vitro diagnostic products become effective in September 1974. However, it is estimated that the number will exceed 10,000 individual products. The Communicable Disease Center has been accumulating data on diagnostic kits for several years. Our information indicates that between 1971 and 1972 the number of these kits increased from 1,233 to 1,499—an increase of 266, or 21.5 percent.

DISEASE CONTROL ACTIVITIES

Mr. FLOOD. On this matter of disease control, you are asking for 10 new jobs here for your disease investigations, surveillance, and control activities. Why do you need 10 new positions when you have now 1,495.

Dr. SENCER. Yes, sir. This is a new area of considerable activity concerned with the prevention of infections caused in hospitals.

Mr. FLOOD. Let's put two questions together then. In your general statement you say, "There is one area where we feel we have fallen short. That is in the prevention of hospital infection." Put the two questions into one and show us how will this budget help you address that problem?

Dr. SENCER. We estimate that 5 percent of all admissions to general acute care hospitals develop an infection while they are in the hospital, and that this adds an average of 3 days to the hospital stay. At the cost of a day of hospitalization you can see what this adds up to in terms of drain on the medical dollar as well as suffering for the individual.

We are in the process of developing a system using sentinel hospitals across the country, some 83 sentinel hospitals that are developing a common reporting system.

Mr. FLOOD. What is a sentinel hospital?

Dr. SENCER. It is a poor choice of words. It is a hospital that has agreed to voluntarily report to us all infections that occur within the hospital, with certain basic data, so that we can try and pick up early indications.

Mr. FLOOD. What can we do to make all hospitals report to you whether they like it or not?

Dr. SENCER. I would hate to see a system as great as that, because this would mean so many million reports of infections coming in a year. That would be awfully difficult to digest. We think that with about 80 hospitals that we have at the present time, we can get sensitive enough information to pick up problems that are beginning to occur. A good example of this has been the recent report in two or three hospitals that reported to us a sudden increase in hepatitis in individuals who had been receiving a certain biological product. We were able, starting with the three or four cases, to look at the people who had received this biologic product across the country and had found that it was contaminated with the virus of hepatitis and the Food and Drug Administration has issued a recall.

HEALTH EDUCATION PROGRAM

Mr. **Flood**. With reference to a health education program you are requesting an additional $1.3 million in fiscal year 1975 for a national health education program. Will you tell the committee what this is and why is there a need for such a program?

Dr. **Sencer**. Let me explain the $1.3 million, sir. A part of the current budget is for the National Clearinghouse of Smoking and Health. The increase for 1975 expands beyond that program. As Dr. Edwards mentioned yesterday, the President's Committee on Health Education pointed out that there was no concerted effort being made in this country to provide education to the consumers of health services. We have many splinter things that are going on. We have educational programs that go along with our venereal disease program which are very important. We have educational programs that go along with hypertension, but there is no program that is really aimed at educating the consumer on how best he can use the health care system to stay in good health or get care at an early stage if needed.

The program that is envisioned is not a categorical health education program that will take over the educational activities being done by voluntary agencies or by other parts of the Public Health Service, but will aim at groups that are not getting good health education at the present time.

For example, school health education of elementary school children is very inadequate at the present time. I have seen the things that my own children bring home. There are cartoon books about nutrition that are giving very bad information.

Another example: At the present time, the high risk group for high blood pressure, for cancer of the cervix, for gonorrhea, for cancer of the lung is black women. The highest rates of all of these diseases are seen in black women. There needs to be a concerted effort through neighborhood groups to bring to black women better information about their health. We see the need for developing programs for specific population groups rather than specific diseases.

Also, as Dr. Edwards mentioned, part of this money would be devoted to helping establish a national center for health education outside the Government. It would only be expended if there were funds available from the private sector. We have under way this fiscal year a study to see whether the private sector, the insurance industries, the voluntary agencies, would band together to support such a national center for health education.

Mr. **Flood**. Your justification states that you will fund "experimental programs of delivering basic health education as against health information." What does that mean?

Dr. **Sencer**. There are many things done under the guise of health education that are really just providing somebody with a pamphlet about a disease. "Go get your blood pressure checked." What we envision are truly educational programs that, over a period of time, say in the schools, get children with a good enough understanding of their body and its functions so that they will be able to ma[illegible] informed decisions.

For example, if we teach children enough about their lungs, its structure, its function, its necessity, and what things will do to it, what air pollution will do to it, what smoking will do to their lungs, if we did teach them that at the age of 7, 9, and 12, will they start smoking at the age 16? These are the experimental approaches that we would like to take.

Mr. **Flood**. How is that going to benefit the so-called man in the street?

Dr. **Sencer**. That is just one example. I would think that there are other ways, through developing programs of continuing education in the offices of health maintenance organizations, where people wait for the doctor—and I am sure that even in HMO they will have to wait, there is an opportunity by a trained individual to be talking to them about their health situation, what choices they can make for better health, obesity, smoking.

Mr. **Flood**. This isn't going to be an expanded smoking and health program?

Dr. **Sencer**. No, sir.

Mr. **Flood**. You are going to address other subjects as well?

Dr. **Sencer**. Yes. I used smoking just as an example.

OCCUPATIONAL SAFETY AND HEALTH

Mr. **Flood**. Now on occupational health, I am sure we have discussed this elsewhere in the record, but let's make it crystal clear here. Why is there a reduction of $3.3 million in the budget for the National Institute for Occupational Safety and Health?

Dr. **Sencer**. The reduction in the budget, Mr. Chairman, reflects a one-time appropriation in 1974 which was for the purpose of improving clinical facilities for pulmonary disease in areas where coal miners work.

Mr. **Flood**. Why have you reduced the research grants by 50 percent?

Dr. **Sencer**. This again is a reduction that shows up because of carryover money. The actual research grant appropriation is the same as it was last year.

Mr. **Flood**. In the budget justifications for fiscal year 1974, you showed 563 jobs. This year in your justifications you show in the column for fiscal year 1974, 525 jobs. What did you do, cut that program during the year?

Dr. **Sencer**. Actually, sir, my table doesn't show the same numbers, but we are requesting 40 new positions in the NIOSH budget for fiscal 1975 over the adjusted figures in 1974. As has been mentioned before, there was a reduction in the staff of NIOSH in 1974 of 96, and this request is an increase of 40 over the revised 1974 budget.

Mr. **Flood**. Last year this committee expressed in its report that it did not agree with any reduction of 96 positions for fiscal 1974, but it appears you went ahead and made the cut anyway. Have you decided this program is a low priority?

Dr. **Sencer**. Mr. Chairman, yesterday I think Mr. Obey asked me how many positions we had requested for 1975. We did request 135 positions, which was above the level that this committee and the Senate had recommended.

Mr. **Flood**. Let's get it straight. In the 1974 budget you propose 563 jobs for NIOSH. That is a cut of 96 jobs from the 659 which they had in 1973. Both the House and the Senate committee reports expressly disapproved the proposed reduction. Where are we? Was the congressional directive deliberately ignored?

Dr. **Sencer**. I think the report restored to the President's budget 211 positions for the preventive health services activity of which 96 were for NIOSH. These were not used.

Mr. **Flood**. You heard the question, and the answers, Y-E-S!

Dr. **Sencer**. Yes.

Mr. **Flood**. In your general statement you said that NIOSH personnel responded to some 200 requests for health hazard evaluations. How many of these evaluations revealed substances with a potential toxic effect.

Dr. **Sencer**. Could I ask Dr. Key to respond to that, please?

Dr. **Key**. Mr. Chairman, all of them had potential toxic effects. Looking at the total that we have done since the beginning of our implementation of the act, there were 364 such requests received. We have completed 256 of these, and have made a determination on a little over 100 as to whether there is toxicity or no toxicity. I don't have the breakdown of that 100 that have had final determinations, but I will be glad to supply that for the record.

[The information follows:]

BREAKDOWN OF 100 HAZARD EVALUATION DETERMINATIONS FOR TOXICITY

Report Date (Date of Transmission to DOL)	Establishment Location	Toxicity Determination (No. of Substances) Determined Toxic	Toxicity Determination (No. of Substances) Determined Not Toxic
5/73	Augusta, Kansas	0	1
5/73	Denver, Colorado	0	4
5/73	Cincinnati, Ohio	0	2
5/73	Hyattsville, Maryland	0	2
5/73	Pocatello, Idaho	0	4
6/73	Little Rock, Arkansas	0	2
6/73	Grenada, Mississippi	0	1
6/73	New Boston, Ohio	3	0
6/73	Cambridge, Massachusetts	0	3
6/73	Bauxite, Arkansas	3	2
6/73	Clarksburg, West Virginia	1	0
6/73	Newport, Tennessee	1	0
6/73	Newport, Tennessee	2	0
6/73	Dublin, California	1	2
6/73	Loraine, Ohio	1	8
6/73	Cincinnati, Ohio	0	4
6/73	Missoula, Montana	0	4
7/73	Lafayette, Indiana	0	5
7/73	Loves Park, Illinois	0	3
7/73	Chelsea, Michigan	2	3
7/73	Alton, Illinois	0	1
8/73	Reading, Pennsylvania	0	2
8/73	Huntingdon, Pennsylvania	0	5
8/73	E. Stroudsburg, Pennsylvania	1	0
8/73	Los Angeles, California	0	1
8/73	Bayonne, New Jersey	0	1
8/73	Denver, Colorado	0	1
9/73	Lima, Ohio	0	1
9/73	Warren, Michigan	0	1
9/73	Kansas City, Missouri	0	5
9/73	St. Louis, Missouri	1	2
9/73	La Veta, Colorado	0	2
9/73	Tumwater, Washington	1	0
9/73	Olympia, Washington	1	0
9/73	Renton, Washington	1	0
9/73	Puyallup, Washington	1	0
9/73	Renton, Washington	1	0
9/73	Seattle, Washington	1	0
9/73	Taylor, Michigan	0	9
9/73	St. Paul, Minnesota	0	1
10/73	Yarmouth, Maine	0	3
10/73	Lee's Summit, Missouri	0	1
10/73	Berkeley, California	0	2
10/73	San Lorenzo, California	1	0
10/73	Ogden, Utah	0	1

Report Date (Date of Transmission to DOL)	Establishment Location	Toxicity Determination (No. of Substances)	
		Determined Toxic	Determined Not Toxic
1/72	Dearborn, Michigan	2	0
3/72	St. Louis, Missouri	1	19
4/72	Forest Park, Georgia	0	1
5/72	Portage, Indiana	4	0
5/72	Grantsville, Maryland	0	6
5/72	Bloomsburg, Pennsylvania	0	3
6/72	Streater, Illinois	0	3
6/72	Atlanta, Georgia	1	0
6/72	Sharonville, Ohio	1	0
6/72	Cincinnati, Ohio	2	2
6/72	Rutherford, New Jersey	0	4
6/72	Richmond, California	0	1
7/72	Hamilton, Ohio	1	0
8/-2	Lima, Ohio	0	2
8/72	Salt Lake City, Utah	0	4
8/72	Los Angeles, California	0	1
8/72	Lima, Ohio	1	0
8/72	New Boston, Ohio	1	0
8/72	Belcamp, Maryland	1	0
9/72	Danville, Illinois	2	2
9/72	Jefferson, Ohio	1	0
12/72	Crawfordsville, Indiana	0	10
12/72	Bucyrus, Ohio	0	1
12/72	Kansas City, Missouri	0	4
12/72	Ashtabula, Ohio	0	7
1/73	Barberton, Ohio	0	6
2/73	Mishawaka, Indiana	0	8
2/73	Dayton, Ohio	0	1
2/73	Goshen, New York	0	2
3/73	Denver, Colorado	0	1
3/73	West Hartford, Connecticut	0	2
3/73	Paris, Tennessee	2	7
3/73	Denver, Colorado	0	1
3/73	Clinton, Michigan	1	7
3/73	Sheffield, Illinois	1	2
4/73	Mountain View, California	0	6

Report Date (Date of Transmission to DOL)	Establishment Location	Toxicity Determination (No. of Substances)	
		Determined Toxic	Determined Not Toxic
10/73	Honolulu, Hawaii	0	1
10/73	Flint, Michigan	0	1
10/73	Tigard, Oregon	2	0
10/73	Franklin, Indiana	0	4
10/73	Bloomfield, New Jersey	3	0
10/73	Madisonville, Kentucky	1	0
10/73	Sioux Falls, South Dakota	1	0
11/73	Macomb, Illinois	2	0
11/73	Nitro, West Virginia	1	0
11/73	Boulder, Colorado	1	0
11/73	Barboursville, West Virginia	12	0
11/73	San Bernardino, California	4	0
11/73	Menasha, Wisconsin	0	1
11/73	Los Angeles, California	0	3
12/73	Wyoming, Michigan	0	4
12/73	Los Angeles, California	0	5
12/73	Fairfield, Illinois	0	1
12/73	Chicago, Illinois	0	1
12/73	Pawcatuck, Connecticut	0	3
12/73	Steubenville, Ohio	0	1
12/73	Follansbee, West Virginia	1	0
12/73	Ypsilanti, Michigan	1	0
		74	227

(Note: Of the 103 Hazard Evaluations completed (104 reports), 43 had at least one substance determined toxic.)

POTENTIALLY HAZARDOUS SUBSTANCES

Mr. **Flood.** What do you do when you discover that a particular substance is potentially hazardous?

Dr. **Key.** We transmit the determination to the Department of Labor, and make a recommendation for controlling the situation. Most of these recommendations are in terms of work practices, however, rather than a new limit.

Mr. **Flood.** How long does it take from the time that you identify a substance as being potentially hazardous until you take corrective action? In other words, will these forty additional positions shorten that time lag?

Dr. **Sencer.** Mr. Chairman, I think there is a little bit of a misconception here. We cannot take the corrective action. We can make the recommendation to the Department of Labor, so that they take the corrective action. The National Institute for Occupational Safety and Health is not the enforcement arm of this. It is the Department of Labor's duty.

Yesterday we were talking about the number of criteria documents that have been transmitted to the Department of Labor. At the present time we have sent 16 criteria documents to the Department of Labor, and yet only one standard has been promulgated by the Department of Labor.

Mr. **Flood.** You know the position of the Senate. You know the position of the House. Do you think it would help any if we had said please, or even if we went so far as to say pretty please?

Dr. **Sencer.** I doubt it, sir.

Mr. **Flood.** Well, how do you coordinate your efforts for the occupational safety and health administration of the Department of Labor?

Dr. **Sencer.** As we have mentioned in Dr. Edward's testimony yesterday, Mr. Chairman, we do have joint planning with the Department of Labor. Our 1975 budget was jointly reviewed by the examiners at OMB for labor and health. We have personnel assigned from the National Institute for Occupational Safety and Health to work in the Office of the Assistant Secretary of Labor. Our regional coordination is very close. Both OSHA and NIOSH have program directors in each regional office who jointly review all of the State programs and State plans.

EMPLOYMENT CEILINGS

Mr. **Flood.** Let's get this straight. Have you been given any employment ceilings for 1974 and 1975 which are different from the numbers of positions shown in the budget? If so, what are they?

Dr. **Sencer.** No, sir. They are the same.

Mr. **Flood.** Mr. Michel.

VENEREAL DISEASES

Mr. **Michel.** Thank you, Mr. Chairman. First, Dr. Sencer, I don't hand out very many bouquets in this committee or commend witnesses very often, but I do want to commend you for one thing specifically: That is giving as much visibility in your testimony, as much attention first and foremost to the problem of venereal disease control. You very well know our personal interest in that over a period of years when we were scrapping for as little as a half million dollars a number of years ago.

Dr. SENCER. $600,000.

Mr. MICHEL. Trying to get something moving, right, and to see in your testimony that that is the first item talked about, and several pages devoted to it, certainly is to your credit.

I wonder if you can trace, Doctor, the direct casual link between this expanded venereal disease program and the 2.4 percent decline in infectious syphilis during the first 6 months of 1974? Really to what do you attribute the decline?

Dr. SENCER. We attribute the decline, Mr. Michel, to the increasing numbers of individuals being screened for gonorrhea. By screening individuals for gonorrhea we are finding people who are incubating their syphilis, and by treating their gonorrhea we simultaneously treat their syphilis before it has become infectious. Syphilis does not become infectious for several weeks after infection, while gonorrhea becomes infectious within a week, so that if we are treating more people with gonorrhea, we are automatically stopping the transmission of syphilis.

Mr. MICHEL. You say that the number of females diagnosed with gonorrhea during 1974 increased by more than 36 percent over 1972 while male cases increased by only 2 percent. Is this difference the result of the screening program?

Dr. SENCER. This is the result of the increased effort that is being put into screening. As we discussed considerably last year, much of the gonorrhea in females is asymptomatic, and we, by finding the cases, are preventing it from occurring in males.

Mr. MICHEL. Last year you spoke of reaching some 4 million people in fiscal year 1974 with these venereal disease programs. How many would we expect to be reaching this year, or in fiscal year 1975? Would it be an increase, a decrease, about the same?

Dr. SENCER. It is a slight increase. I think the approach has been pretty much a saturation one. We are now beginning to concentrate on specialized population groups that we are finding at perhaps higher risk. Recent studies have shown that if you find a woman who has asymptomatic gonorrhea and treat her, and then find a way to reexamine her 12 weeks later, she quite likely has become reinfected, and we get a much higher yield of case finding. In this way, so that in addition to the broad scale screening of around 600,000 a month, we do plan to concentrate more on segments of the population that we have identified that are at higher risk.

SCREENING OF FEMALES VERSUS MALES

Mr. MICHEL. Are we making a mistake by putting all emphasis on this screening of females than men, equal treatment for the male population?

Dr. SENCER. Mrs. Green brought this up earlier, and I would say that we have been able to identify certain groups of males who do have asymptomatic gonorrhea also, and we are pushing efforts toward them.

EPIDEMIOLOGY

Mr. MICHEL. You make mention here on page 11 that the major emphasis during 1975 will be placed on improving the quality of epidemiology being performed. I wonder for the record, not taking the time here, to explain just what epidemiology is?

[The information follows:]

EXPLANATION OF VENEREAL DISEASE EPIDEMIOLOGY

Epidemiology is the science concerned with the factors and conditions that determine the occurrence and distribution of disease. In venereal disease control, the word "epidemiology" is used to describe a series of activities that are undertaken when an infectious or recently infectious case is discovered. They include confidential interviewing of persons, and the followup and treatment of persons who may have been exposed to the disease. These activities are important in identifying and treating individuals who do not suspect that they are infected, and are critical to the prevention of disease transmission.

VD EDUCATION PROGRAMS

Mr. MICHEL. How do you really approach this problem of educating young people, particularly to prevent exposure or reexposure to infection?

Dr. SENCER. With difficulty, I guess. We do have programs that have been tried in school systems to talk about sexually transmitted diseases, not talk about family life education or sexeducation, but talking about the diseases and what can be done to prevent their transmission. It is very difficult for a disease control program to talk about changing moral standards or behavior, but we can point out that there are ways in which people can prevent disease or can prevent transmitting it. We feel this is the appropriate role for us to take.

Mr. MICHEL. In the past, I guess we have also talked about new approaches to dealing with this problem. Are there any new methods, anything new that you conceived or devised over the past year, that would give us room for encouragement?

Dr. SENCER. Let me tell you things about which you should not expect immediate encouragement; that is, a vaccine development either for gonorrhea or syphilis. These are being worked on.

Mr. MICHEL. Nothing to report?

Dr. SENCER. There are some scattered scientific reports of being able to demonstrate that in a few animals we have been able to protect against reinfection.

VD RESEARCH BUDGET

Mr. MICHEL. Is the level of research money in the budget to which you are testifying at the same level as last year?

Dr. SENCER. In this budget, and I cannot speak for the NIH budget, is where most of the extramural research is being performed. NIH, with our help this past year, went out and really worked trying to get more good research to be conducted in the external sector, and it is very difficult to interest people in research in these two diseases.

Mr. MICHEL. It is just really not a popular subject to attract?

Dr. SENCER. No, and usually when you put money out, people come to it. This has not happened in the area of venereal disease.

Mr. MICHEL. That is why I commend you again for giving it the focus of attention in the front end of your testimony. It helps to point out the doggone problem we have got, because it is such an unpopular kind of thing. It was talked of in the past in guarded conversation and select company. With those kinds of restraints, we are never going to really make the kind of significant progress that has to be made. Again, if only to point up the necessity for more people becoming actively involved in helping us rid ourselves of a problem, we have got to talk about it.

Dr. SENCER. One of the ways we are trying to do this is to identify all of those people in the country, actually in the world, who are doing research in the sexually transmitted diseases, and bring this together with short compendiums of what they are doing in a directory. We expect to have this directory out within the next month or two.

LEAD-BASED PAINT POISONING

Mr. MICHEL. Let me now ask a couple of questions on lead-based paint poisoning grants to the State labs. How will these State labs be using these grants?

Dr. SENCER. The money will be principally for getting started in equipment, personnel, and training the personnel. Very few States, I think there are only three, have been doing lead analyses in their laboratories.

Mr. MICHEL. Which ones are those?

Dr. SENCER. I will have to supply that.

[The information follows:]

STATES DOING LEAD ANALYSES IN THEIR LABORATORIES

Three State health department laboratories are currently providing lead analysis services to grantee communities. These are New York State, Maryland, and South Carolina.

Mr. MICHEL. What kind of money are we talking about in this area?

Dr. SENCER. We are talking about an average of $150,000 per State, which will get them their equipment, the first year's salary of a technician and the training costs.

Mr. MICHEL. How does your budget this year compare to last year in this area?

Dr. SENCER. There is a one-time appropriation for the State laboratories, which is $4.5 million. Next year the budget returns to its level of $6.5 million.

Mr. MICHEL. When you say next year, you mean fiscal 1975, the one to which you are testifying?

Dr. SENCER. Yes, sir.

MEDICAID

Mr. MICHEL. I wonder if you would provide for the record an estimate of how much medicaid money was used in fiscal year 1973 to screen children for lead-based paint poisoning; and how much do you estimate will be spent in fiscal year 1974 and 1975? Is it possible to come up with that?

Dr. SENCER. We can try, sir.

Mr. MICHEL. That is taking place, is it not?

Dr. SENCER. It was not in 1973. It was started in 1974. We will do our best.

Mr. MICHEL. Of course the reason for mentioning 1973 is we didn't have anything, but what progress we have made since then.

Dr. SENCER. Yes, sir.

[The information follows:]

ESTIMATE OF AMOUNT OF MEDICAID MONEY USED TO SCREEN CHILDREN FOR LEAD-BASED PAINT POISONING

The early and periodic screening, diagnosis and treatment program under medicaid was initiated in fiscal year 1972. Since then, 49 States have implemented some aspects of the program. In 38 of these, a lead test is identified as a reimbursable item, but the extent and costs of lead screening under the program are not known. One of the major roadblocks to implementation of lead screening under medicaid has been the need to establish a capability in blood-lead laboratory service in each State. This need is being met during fiscal year 1974 through the provision of project grant assistance to State health departments.

Mr. MICHEL. I wonder if you would provide for the record an estimate of how much money was used by all of HEW in 1973 to screen children for lead-based paint poisoning and how much you estimate will be spent in fiscal years 1974 and 1975?

Dr. SENCER. Right.

[The information follows:]

AMOUNT OF HEW FUNDS TO SCREEN CHILDREN FOR LEAD-BASED POISONING

In fiscal year 1974, the Center for Disease Control will provide $6,500,000 for project grants to communities for child screening and $4,500,000 to State health departments to strengthen the capabilities of State health laboratories to perform blood lead analysis. A total of $6,500,000 is requested for fiscal year 1975. In addition, approximately $841,000 in direct operations will be spent by the center in support of this program.

Child screening for lead-based paint poisoning is also supported through Neighborhood Health Center project grants, maternal and child health grant programs, and the early and periodic screening, diagnosis and treatment program under medicaid. Since lead screening is only one preventive health activity being carried out as a part of these broader preventive and curative programs, estimates of expenditures are not available.

Mr. MICHEL. I suspect when we get on the floor we will have our annual little argument about the level of funding here. You and I know we could play the chairman's phrase there a little bit, that there are other areas, other little appropriations items where this work really is being done in part but not specifically, as one figure might show here. I think if we have it all together we might be able to put it in better perspective.

DISEASE INVESTIGATIONS

You estimate being involved in over 1,200 disease investigations in 1974. I wonder if you could supply for the record another example or two of major types of investigations that these were. Is that possible?

Dr. SENCER. Yes. We could mention one that is taking place right now. It is not strictly in the United States, but it is to protect the United States. A few weeks ago we were notified by the Pan American Health Organization that there was an outbreak of jungle yellow fever in Panama, about 200 miles east of the Canal Zone, and through the Government of Panama——

Mr. FLOOD. Where was that?

Dr. SENCER. About 200 miles east of the Canal Zone.

Mr. FLOOD. Up the Chagres River?

Dr. SENCER. Yes.

Mr. FLOOD. Indians?

Dr. SENCER. I can give you the name of the town.

Mr. **Michel.** The chairman's specialty in that area is well known, and I support the chairman.

Dr. **Sencer.** It is the Chepo District of Panama. This is an area where they are doing a considerable amount of logging and building a new dam. We were invited down along with the people from the Gorgas Laboratories who had done a very good job of investigating it. Actually it is a very small outbreak of only two cases and eight possible cases. There were two confirmed cases, but the Panamanian Government has done a good job of setting up vaccination stations for all people going into the Chepo District and coming out. The mosquito population in the cities is low enough so there would not be any problem if it did get into the cities.

We were recently called to investigate an outbreak of salmonella that occured in a nursery of newborn children. It turned out that a woman had been admitted to the hospital 1 day before she delivered. She had not been seen by a physician before, was cultured, and they found that she had a particular type of salmonella. Her infant was born the next day and 2 days later developed an acute abdomen, was rushed to surgery and died. Three days later another child in the same nursery became sick with the same organism. At this point it was found that the records hadn't been hooked up. The fact that the woman was infected when she came into the hospital never got into the baby's record in the hospital, and so this chain of infection got started. One of our epidemiologists was called. We instituted a program of personal hygiene in the staff of the nursery, and hopefully the epidemic has been averted.

There has been recently a tremendous amount of illness in the Caribbean area among American individuals who have been taking cruises. There has been an increase in tourism aboard ships in the Caribbean. We had one ship on which over 600 passengers aboard became ill with shigella, a waterborne disease outbreak. We would go on with many, many more.

Mr. **Michel.** In that particular case, as I recall in your testimony, it had to do with the water supply.

Dr. **Sencer.** Yes. We have a picture of this ship taking water aboard in San Juan, P.R., into its potable water supply coming from the fire hydrant, and fire hydrant water is never sanitized.

HOSPITAL INFECTIONS

Mr. **Michel.** Doctor, in your discussion with respect to hospital infections, and here again you were quite frank in your testimony, you recognize there is still a problem here. Then in your exchange with the chairman you mentioned 80 hospitals that you are using currently to put together whatever information it is.

Dr. **Sencer.** It is a surveillance system of infections in hospitals, sir.

Mr. **Michel.** I would guess those hospitals that are participating would be those classified as the better hospitals in the country, would they not?

Dr. **Sencer.** Not necessarily, sir. We have tried to get a cross section of hospitals—small, big, municipal, voluntary. It represents sort of the midstream; not the best, not the worst.

Mr. **Michel.** But then from that you would hope to develop the kind of information you would broadside to all the hospitals as to your findings?

Dr. Sencer. Yes. This is what we do. We have a quarterly report that puts together the information that is derived from these hospitals, examples of what hospitals have done to correct problems, and then this goes out to a much broader mailing list of individuals. In addition, we have training programs where hospital administrators, housekeepers, and nurses come for training in methods of preventing hospital infections. If I could, sir, I would like to expand upon that for a minute. There was quite a bit of interest in the PSRO program yesterday. One of the pieces of information that came out of the hospital infection activity is misuse of antibiotics, how this leads to resistant organisms which, in turn, are one of the major problems with hospital infections. The PSRO has a very interesting program started now to see if there are ways to develop recommendations for appropriate uses of antibiotics to prevent resistance from developing as well as to cure disease. They are working through the American College of Physicians on this. I think this is one of the unpublicized things that the PSRO program is getting at and is a direct result of some of the information that we have derived.

RAT CONTROL PROGRAM

Mr. Michel. You know of the spirited debates we have had, too, on the floor of the House with respect to rat control. Just in a general way, is the problem less severe today than it was 2 years ago?

Dr. Sencer. We can demonstrate in those communities where there have been comprehensive rat control programs that the rat population, as evidenced by rat droppings and the usual measurements, has decreased markedly. Of course, the real concern is going to be what happens when we take the pressure off. When the Federal money goes out, will the community effort, the community sanitation, continue without the Federal aid?

Mr. Michel. Specifically moneywise, how does the 1975 budget compare to 1974, the same?

Dr. Sencer. It is level.

Mr. Flood. Will the gentleman yield?

Mr. Michel. Yes.

Mr. Flood. The thing that concerns me about this is the training of your people in this vector or rat control program for just 2 or 3 days or something like that. You talk about diplomacy. You go ahead, knock on somebody's front door, and say, "Good morning, ma'am, how are your rats in the house this morning?" or something like that. Are you paying any attention to the manner in which you train these people going around in the program?

Dr. Sencer. Yes. The rat control program has just become the responsibility of our organization, and we have beefed up the training component in this. As you say, it is a ticklish matter, but so is it a ticklish matter of knocking on somebody's door and saying, "You have been exposed to venereal disease." I think many of the techniques we have developed to handle this with dignity are being adapted to use in terms of community workers in the rat control program. We have had experience in the venereal disease program of training indigenous people from the inner cities to do some of the investigations and some of the motivation, and it can be done with dignity, sir.

Mr. Flood. My point in asking the question is just so you will know.

Dr. Sencer. Yes.

OCCUPATIONAL SAFETY AND HEALTH

Mr. MICHEL. Let me wind up here with a couple of questions on the occupational safety and health area. What is your congressional mandate in this area?

Dr. SENCER. Could Dr. Key answer that please?

Dr. KEY. Under the Occupational Safety and Health Act, HEW has responsibility for research, for making recommendations for standards to the Department of Labor.

Mr. MICHEL. Was there a deadline on promulgation of those standards?

Dr. KEY. Initially there was a deadline for the promulgation of startup standards by the Department of Labor. We did not enter into that process as defined by the act. These initial standards were national consensus standards and established Federal standards. These were promulgated in May of 1971 by the Department of Labor, and revised, I believe, in October of 1972.

Continuing with HEW's responsibilities, we have responsibility for hazard evaluations.

Mr. MICHEL. Confined to the health area?

Dr. KEY. Yes, sir.

Mr. MICHEL. It is confined to occupational health.

Dr. KEY. We have responsibility for both safety and health research and for recommending both safety and health standards to the Department of Labor. We also have responsibilities in manpower development.

Mr. MICHEL. Are those standards all in being now so far as the health standards? Are they in place or under constant review?

Dr. KEY. The Department of Labor has some 450 health standards on the books. These are numbers only. A complete health standard has many other components in it besides just the number.

There are requirements for a sampling method, an analytical method, labeling, placarding, informing of the employees, recordkeeping, monitoring of the environment, medical monitoring, and first aid. A massive program has recently been undertaken by both NIOSH and OSHA in the Department of Labor to supplement these 400 or so startup standards by supplying the missing requirements. Over the next 2½ to 3 years there will be approximately 400 such supplemental health standards issued.

Mr. MICHEL. How many people in your shop would actually be detailed to the health part of this job? Your shop really has to do only with the health aspects of it rather than the regular safety enforcement factors?

Dr. KEY. We have no responsibility in either health or safety enforcement.

The vast majority of the NIOSH staff have background in health expertise. We are only beginning to develop——

NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH EMPLOYMENT

Mr. MICHEL. How many people are in that shop now?

Dr. KEY. We have about 580 onboard.

Mr. MICHEL. And your budget for 1975 is asking for more or less?

Dr. KEY. Forty new positions.

Mr. OBEY. Will the gentleman yield?

Mr. MICHEL. Yes.

Mr. OBEY. You said you had 580?

Dr. KEY. Yes; Mr. Obey, onboard. We have a number of recruitment actions under way.

Mr. OBEY. Let me ask this question because I am somewhat confused here. The chairman asked how many positions you had onboard, and I read on page 124 of your justifications it is 525. Can you straighten me out on that?

Dr. SENCER. Mr. Obey, the 525 positions are allotted to direct operations in the NIOSH appropriation. Seventy-seven additional are allotted in program direction and show up in that column in the budget. In addition there are nine individuals on reimbursable services.

Mr. OBEY. Thank you.

Mr. MICHEL. These 40 new positions you are requesting, will there be a comparable increase in those that don't fall within this category? You spoke of program direction.

Dr. SENCER. There is no increase in that group. It is all in direct operations, sir.

Mr. MICHEL. That is all, Mr. Chairman.

Mr. FLOOD. Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

Doctor, because of my questions yesterday I don't want you to have the impression that I don't think yours is a well-administered shop. Many people who know a lot more about it than I do seem to feel yours is a very well run shop. I want to give you that due.

Dr. SENCER. Could I interrupt you and apologize for some information I gave you yesterday. I think I gave you some information that I had misinterpreted when given to me, and I would like to set the record straight on the situation in the printing plants.

It is true that the first contact was made around Christmas of 1972 where it was proposed that labor, management, and Government and the industry all get together to begin a comprehensive look at health hazards in the printing industry and the plant in Wisconsin was selected to be the first to develop it.

We were in the factory in March, 1973, did a walk through with the individual

Mr. OBEY. You did two walk throughs didn't you?

Dr. SENCER. Yes. There was the original walk through in 1973 which was a look at the record, a look at the individuals, a look at the plant. In June of 1973 there was an industrial hygiene engineering type survey of the environment. Then I must admit that things got out of hand and we did not get back until January when Mr. Samuels found a volunteer physician to go it. And then things have moved quite well.

It was not well handled.

Mr. OBEY. Thank you.

PROJECT CONTRACTS

I want to return to that but let me ask you something else first. In your statement you say that for 1975 you request an additional 40 positions in order to strengthen your inhouse research capability. What percentage of your work is contracted out now at NIOSH?

Dr. **Sencer.** We can supply a table showing that for the record. Not all of the work that is contracted out is research however.

Dr. Key, would you respond to the actual figures.

Dr. **Key.** In fiscal year 1973 contracts were $6.3 million. In fiscal 1974 our estimate is that the contracts will amount to approximately $13.3 million.

[The information follows:]

TABLE OF PERCENTAGE OF NIOSH WORK CONTRACTED OUT

[Dollars in thousands]

Fiscal year	Expenditure level	Contract		Agreements with other government agencies	
		Amount	Percent	Amount	Percent
1973	$25,670	$6,306	24.6	$1,126	4.4
1974	35,443	13,300	37.5	1,745	4.9
1975	27,859	7,048	25.3	1,258	4.3

[1] Includes 1973 restored funds.

Mr. **Obey.** That is in spite of the language in the committee report which we issued last year on the budget which said "The committee is strongly opposed to delegation of responsibilities for carrying out the Occupational Safety and Health Act to private contractors." In spite of that you are going to be doubling the amount of money spent for contracting next year. Is that right?

Dr. **Sencer.** Yes, sir.

Mr. **Obey.** I am told—correct me if I am wrong—that you contract out over 60 percent of your work.

Dr. **Key.** The area in which most are interested is our criteria documentation, development of criteria documents. Initially we contracted out about 80 percent of it. It is now up to about 90 percent.

Mr. **Obey.** It is up to 90 percent that you contract out?

Dr. **Key.** Yes, sir.

CONTRACTS VERSUS INTRAMURAL RESEARCH

Mr. **Obey.** That is really developing your in-house capabilities?

I have also been told that an internal NIOSH estimate on what should be contracted out is about 30 percent. Is that correct or not?

Dr. **Key.** I am not familiar with that estimate. I would like to have as much in-house capability as we do by contracts. But being realistic and faced with the necessity of getting the job done——

Mr. **Obey.** I understand that. I am not criticizing you. I am trying to criticize the budget you have been given to work with, and I am trying to build a record to show that in plain English it is a completely inadequate and lousy budget.

In contracting, are you familiar with the awarding of a contract to Agatha?

Dr. **Key.** Yes.

Mr. **Obey.** And that payment has been held up I understand because of inaccurate, poorly written and tardily submitted reports. Is that right?

Dr. **Key**. I am not familiar with the particulars of this particular contract. We do have a contract with Agatha corporation to produce several criteria documents.

I do know that one document in particular ran into a little difficulty, but this is not unusual among our contractors. We have to work with them in order to develop the kind of finished products we would like to have.

Mr. **Obey**. What I am trying to get at is this: I am told that, at least in the eyes of some people, there may have been a conflict of interest in that contract because the gentleman who owned Agatha at the time he was given that contract was doing environmental health consulting for industry too, and there might be at least an indirect conflict of interest in that. I want to make clear I am not asserting there was. It has been suggested to me there may have been, and I wanted to get your response to it.

Dr. **Sencer**. This is the first I have heard of it and let us look into it and provide for the record a statement of what is going on. If there is conflict of interest, we will certainly take action. This is the first we have heard of it.

[The information follows:]

STATUS OF AGATHA CONTRACT WITH NIOSH

Since the initiation of contract activities in the production of criteria documents, National Institute for Occupational Safety Health has been concerned about "apparent" conflicts of interest over and above the legal requirements of the responsibility of contractors as spelled out in Federal Procurement Regulations (Subpart 1–1.12 of Title 41, Code of Federal Regulations). At one stage, National Institute for Occupational Safety Health restricted the participation of "any trade union, trade association, or party who controls or whose employees or members are engaged in the manufacture, use, sale, or distribution of . . ." a particular substance from contract participation in criteria documentation for that substance. Later, it was felt that this restriction was resulting in the loss of sources of significant technical information and experience.

Accordingly, at the November 17, 1972 public meeting of the National Advisory Committee on Occupational Safety and Health, a full discussion of the ramifications of open competitive procurement was held on the record. The consensus of the committee was that open competitive procurement should be held for the production of criteria document with certain safeguards proposed by National Institute for Occupational Safety Health. As a result, National Institute for Occupational Safety Health now does not impose the former restriction but imposes the following safeguards in each contract documentation process.

1. Contractor develops the criteria document and recommends two alternative limits and gives the rationale for the selection of each. National Institute for Occupational Safety Health decides which of the two recommended limits or other limit is to be used in further drafts.

2. All toxicity studies and data sources used in preparing criteria documents are made available to National Institute for Occupational Safety Health and its consultants for review. No proprietary information or data which cannot be made public is permitted for use in any manner for preparation of the criteria document.

3. An internal and external review is conducted by National Institute for Occupational Safety Health, with external review panels made up of professionals from industry, organized labor, universities, and government agencies.

In the particular procurement with Agatha corporation, a competitive contract was awarded on a cost-plus-fixed-fee basis on March 26, 1973 for the development of six criteria documents. It is pertinent to note that the former restrictive policy would not have prohibited a contractor whose consultative practice included industry. Subsequent to the award of the contract, a principal officer of the firm accepted a position with a major corporation which either produces or uses one or more of the substances covered by the contract. He has retained his interest in Agatha corporation. However, the safeguards which are imposed on all contracts are deemed adequate to insure the validity of the documents being prepared by Agatha.

Mr. OBEY. I state this because I think it is an example of what happens when you rely on the contracting device and that is the reason this committee put that language in the report last year. I just think it is very important, for obvious reasons.

Mr. MICHEL. Will the gentleman yield?

Mr. OBEY. Yes.

Mr. MICHEL. I guess part of the difference, is it not, is whether or not we in the Congress think it is a better route to go with permanent employees or out on contract.

Just for the sake of variation of this discussion in a little more depth, would it be fair to say your approach is one that, if it is a one-shot proposition over just a short period of time to have information developed to arrive at certain standards or give you the kind of information you need to communicate out to industry as to whether or not they are adhering to good health standards, it is much better to go the contract route there and not be subject to intensive padding of the Federal payroll for endless years? Is that a valid conclusion?

Dr. KEY. Yes; that makes sense. And we frequently initiate contracts out on the basis that it would be uneconomical for us to tool up to do a one-time short-term job.

Mr. OBEY. But, Dr. Key, I still gather from your previous statement a couple of minutes ago that while you are at the figure of 90 percent in terms of contracting, you really personally don't believe that is a healthy situation, that it is over balanced in the direction of contrasting. Is that correct?

Dr. KEY. That is correct.

CRITERIA DOCUMENTS

Mr. OBEY. Let me ask some other questions again to try to clarify a point about how many new positions are necessary.

In 1973 HEW projected that you would be able to prepare 20 to 30 criteria packages. Is that correct?

Dr. KEY. With the level of funding and positions at that time.

Mr. OBEY. That is what you projected you could do?

Dr. KEY. Yes, sir.

Mr. OBEY. How many did you actually do? I am told you actually produced six.

Dr. KEY. We are talking about fiscal 1973 now?

Mr. OBEY. Yes.

Dr. KEY. That is correct.

Mr. OBEY. In 1974 you projected you would be able to do 18 with your budget projection. You will be able to produce within that time how many?

Dr. KEY. In fiscal 1974, a more realistic figure would be nine transmitted to the Department of Labor.

Mr. OBEY. In 1975 you project you will be able to finish 14. In light of the sharp reductions in the previous 2 years, is that figure also likely to drop?

Dr. KEY. No, sir, that should rise by two or three because the ones that slipped in 1974 will come out in 1975.

I would like to add that we have some 40 criteria documents in various stages of production through the contract process. These are coming out at various points in time. Though we may run into technical difficulties in bringing some of these to completion on time, they will eventually be brought to completion.

Mr. OBEY. The point is right now the vast majority of American workers are not covered at all by standards.

Dr. SENCER. The only workers covered by complete health standards are those in the asbestos industry.

Mr. OBEY. That is OSHA has only produced one. You have produced more than that.

Dr. SENCER. We have produced 16 criteria documents which don't have the force of enforcement.

Mr. OBEY. Mr. Chairman, could I at this point insert in the record the text of a letter from Secretary Richardson of July 25, 1972?

Mr. FLOOD. Without objection.

[The letter follows:]

SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., July 25, 1972.

Hon. WARREN G. MAGNUSON,
Chairman, Subcommitee on Labor and Heatlh, Education, and Welfare, Committee on Appropriations, U.S. Senate, Washington, D.C.

DEAR SENATOR MAGNUSON: This supplements the tabulation submitted by this Department to your subcommittee staff in the anticipation of the meeting of the conferees on the Labor-HEW 1973 appropriations bill.

I would like to emphasize, first, that the increases in both the House and Senate versions of the bill are a matter of serious concern in the light of the overall budgetary situation. On the basis of our detailed arguments in the tabulation, I urge that the action of the conferees be held to the lower of the House- or Senate-passed levels on an item-by-item basis.

There is, however, one exception which I particularly want to bring to your attention: the appropriation for the occupational health and safety activities of the Health Services and Mental Health Administration.

Since the budget was submitted, I have become very concerned about the rate at which new health and safety standards are being promulgated. We have so far recommended only five such standards: asbestos, beryllium, carbon monoxide, heat stress, and noise. The budget estimate was built on the assumption that we would recommend 20–30 additional standards in fiscal year 1973. I now feel that we should accelerate this pace to 40–60 standards.

The budget requested and the House approved $28,842,000 for occupational safety and health activities of the Department. The Senate bill, however, contains $63,842,000, $35 million more than the House allowance and the budget request. I would urge you and the other Senate conferees to retain $10 million of the Senate increase over the budget so that the production of safety standards can be accelerated. The protection of the health and safety of millions of men and women at their places of work makes it imperative that we develop and promulgate health and safety standards as rapidly as we possibly can.

With kindest regards,

Sincerely,

ELLIOTT RICHARDSON,
Secretary.

Mr. OBEY. In that letter, Mr. Richardson estimated that they would be able to recommend 20 to 30 criteria packages for 1973, and he said, "I now feel we should accelerate this pace to 40 to 60 standards."

Then he said, "I would urge you and the other Senate conferees"—this is a letter to Senator Magnuson—"to accept $10 million of Senate increase over the budget so that the production of safety standards can be accelerated." I think it is pretty apparent from this testimony that far from being accelerated, the picture has been just the opposite. So I would ask you, Doctor, in light of that fact, how much money do you think you would need to be able to achieve what Secretary Richardson said should be achieved back in 1972; namely, 40 to 60 standards?

Dr. KEY. I can give you an approximation based on our present level of expenditure which results in producing about 14 documents a year. In order to double this effort, it would take about 10 to 14 positions and $2 million.

Mr. OBEY. To double it would take 10 to 14 positions and $2 million?

Dr. KEY. That is right.

Mr. OBEY. And if you were to triple it?

Dr. KEY. To triple it, it would be twice that much.

Mr. OBEY. So it would be $2 million, you say?

Dr. KEY. Ten to fourteen positions and approximately $2 million to double it.

Mr. OBEY. In other words, to achieve Secretary Richardson's goal, you would have to add——

Dr. KEY. He was up to 40 to 60, I believe.

Mr. OBEY [continuing]. You would have to add $6 million.

Mr. FLOOD. Off the record.

[Discussion off the record.]

NIOSH ORGANIZATION STRUCTURE

Mr. OBEY. Let me ask you a couple of other questions. Would you describe for me how NIOSH is structured? What divisions do you have in NIOSH?

Dr. SENCER. They are undergoing a reorganization at the present time, Mr. Obey. This hasn't been completely cleared as yet.

Mr. OBEY. Before the reorganization, what are your divisions?

Dr. KEY. We have a number of supportive staff offices and a number of operating divisions.

In Cincinnati, the operation divisions are the Division of Laboratories and Criteria Development, Division of Technical Services, Division of Training, Division of Field Studies and Clinical Investigations.

In Morgantown, W. Va., we have the Appalachian Laboratory for Occupational Respiratory Diseases which is equivalent to a division and which implements our responsibilities under the Coal Mine Health and Safety Act. We have a small division in Rockville, the Division of Occupational Health Programs.

Mr. OBEY. Could you explain for the record, rather than doing it here, exactly what each of those divisions does?

Dr. KEY. Surely.

[The information follows:]

FUNCTIONS OF EACH NIOSH OFFICE AND DIVISION

OFFICE OF THE DIRECTOR

(1) Plans, directs, coordinates, and evaluates the operations of the Institute; (2) maintains liaison with, and provides advice and assistance to, the U.S. Department of Labor, the U.S. Department of Interior, other Federal agencies, State and local government agencies, international health organizations, and

outside groups; (3) provides coordination with the Federal Health Programs Service's occupational health activities for Federal employees; and (4) provides policy guidance and coordination to occupation safety and health activities in the regional offices.

OFFICE OF TECHNICAL PUBLICATIONS

(1) Assists and advises the Institute Director and the divisions on public information policies and activities; (2) provides information materials for response to public inquiries; (3) coordinates printing, publication, and clearance procedures for the Institute; and (4) assists in developing displays, exhibits, and illustrations.

OFFICE OF EXTRAMURAL ACTIVITIES

(1) Advises the Institute Director on matters relating to the development and progress of Institute-supported external research; (2) in cooperation with the offices and operating divisions of the Institute, stimulates research, training, and demonstration grants in relevant priority areas; and (3) administers the management aspects of the Institute's grants programs by receiving, reviewing, analyzing, and evaluating all grant applications.

OFFICE OF ADMINISTRATIVE MANAGEMENT

(1) Provides management information, advice, and guidance to the Institute director; (2) coordinates all management activities in the conduct of finance, personnel, and procurement functions; (3) relates administrative management activities to programs; and (4) develops necessary policies, procedures, and operations, and provides such special reports and studies as may be required in the management area.

OFFICE OF PLANNING AND RESOURCE MANAGEMENT

(1) Plans and coordinates the strategy and philosophy of operation of the Institute regarding mission and objectives; (2) conducts or participates in special studies for program planning and evaluation; (3) conducts the necessary control functions to assure operational compliance toward program objectives within the Institute; and (4) provides management systems consultation and analyses.

OFFICE OF RESEARCH AND STANDARDS DEVELOPMENT

(1) Reviews existing scientific criteria for health and safety standards and assesses through priority systems the needs for additional research program areas for criteria development; and (2) coordinates and maintains an overview of research activities in the operating divisions of the Institute with the ultimate aim toward finalization of criteria and standards.

OFFICE OF MANPOWER DEVELOPMENT

(1) Provides policy guidance and evaluates the Institute's manpower development and training activities; (2) advises the Institute director on national health manpower needs related to occupational safety and health, and relates to other Federal agencies regarding occupational safety and health manpower needs; and (3) conducts equal employment opportunity activities of the Institute as part of the total CDC–EEO program.

OFFICE OF OCCUPATIONAL HEALTH SURVEILLANCE AND BIOMETRICS

(1) Operates as the principal statistical and data research unit in the Institute; (2) monitors new as well as existing occupational hazards, and maintains surveillance on the incidence of occupational illness and disease; (3) in coordination with the U.S. Department of Labor, establishes a priority list for the conduct of research and the development of standards; (4) develops and conducts record studies of work population groups to determine the national trends and problem areas related to job health and safety, and provides health policy guidance in epidemiology; and (5) coordinates the Institute's electronic data processing requirements, to insure that adequate computer facilities and services are available.

OFFICE OF THE ASSOCIATE DIRECTOR—WASHINGTON OPERATIONS

Provides for program coordination and policy guidance and direction of the operations of the division of occupational health programs and the Appalachian Laboratory for Occupational Respiratory Diseases (ALFORD).

DIVISION OF OCCUPATIONAL HEALTH PROGRAMS

(1) Promotes occupational health programs at the State and local governmental levels as well as in industry and agriculture; (2) provides technical guidance in the development of occupational health programs; and (3) correlates the practice of occupational medicine in industry with the total delivery of health services.

APPALACHIAN LABORATORY FOR OCCUPATIONAL RESPIRATORY DISEASES

(1) Conducts studies of the incidence and prevalance of occupational respiratory diseases in specific work groups with particular emphasis on coal workers' pneumoconiosis; and (2) provides medical and engineering research and service to fulfill the Institute's responsibilities under the Federal Coal Mine Health and Safety Act of 1969.

OFFICE OF ASSOCIATE DIRECTOR (CINCINNATI OPERATIONS)

(1) Provides for program coordination and policy guidance and direction of the operations of the Division of Laboratories and Criteria Development, the Division of Field Studiees and Clinical Investigations, the Division of Technical Services, and the Division of Training and (2) manages the NIOSH Western Area Occupational Health Laboratory that houses components of three of the Divisions listed above.

DIVISION OF LABORATORIES AND CRITERIA DEVELOPMENT

(1) Develops criteria for standards for the control of chemical, biological, and physical hazards to the health and safety of the working population, and initiates standard methodology and instrumentation for the detection, evaluation, and control of such hazards; (2) evaluates the toxicity, health, and safety hazards of industrial substances, processes, and other agents, as well as current research requirements and regulations; (3) conducts methodology studies for evaluating the varying capacity of workers to withstand physical and psychological responses; (4) provides for equipment development, analytical service, and calibration needs of other operating divisions with the Institute, and maintains an analytical and calibrations service for the U.S. Department of Labor; and (5) evaluates and certifies the performance of safety and health equipment.

DIVISION OF FIELD STUDIES AND CLINICAL INVESTIGATIONS

(1) Conducts nationwide studies, surveys, and comprehensive analyses to determine the health status of the working population, including the incidence and prevalence of disease and injury; and (2) initiates studies to determine chronic and long-term effects of work-related exposures to toxic and hazardous substances.

DIVISION OF TECHNICAL SERVICES

(1) Provides demonstrations, technical assistance, and consultation to public and private agencies responsible for the control of occupational diseases and accidental work injuries; (2) through the regional offices and its central staff serves as the focal point for the review of State plans and grants with the U.S. Department of Labor and makes the initial responses to requests for hazards evaluations; (3) in cooperation with the Office of Extramural Activities, stimulates, programs, and monitors demonstration grants for new and innovative methods of recognizing, evaluating, and controlling occupational hazards; (4) prepares manuals of good practice for safe work procedures; and (5) operates the technical information inquiry service of the Institute.

DIVISION OF TRAINING

(1) Develops and plans short-term training activities for Federal, State, and local governments, industry, and other appropriate organizations in the field of occupational safety and health; and (2) conducts such short-term training.

BUDGET FOR NIOSH DIVISIONS

Mr. Obey. Could you tell me what the budget would be now for each of those divisions?

Dr. Sencer. We would have to do that for the record.

Mr. Obey. Give me what the budget was for the last fiscal year and what it would be for this fiscal year request. And could you give me a comparison for each division as well?

Dr. Sencer. Yes.

[The information follows:]

NIOSH 1974 BUDGET BY OFFICE AND DIVISION

[Dollars in millions]

Organization	Positions	Amount
Office of the Director	44	1.0
Office of Technical Publications	8	.2
Office of Extramural Activities	11	3.9
Office of Administrative Management	55	1.8
Office of Planning and Resource Management	8	.5
Office of Research and Standards Development	30	3.7
Office of Manpower Development	10	.3
Office of Occupational Health Surveillance and Biometrics	28	2.2
Division of Laboratories and Criteria Development	193	9.6
Division of Field Studies and Clinical Investigations	40	2.2
Division of Occupational Health Programs	4	4.2
Division of Training	21	.7
Regions	29	.8
Appalachian Laboratory for Occupational Respiratory Diseases	78	2.7
Division of Technical Services	52	1.6
Total	[1]611	[2]35.4

[1] Includes 9 positions supported from reimbursements.
[2] Includes 1973 funds restored.

Mr. Obey. Let me ask you this: Your Field Studies Division I think was the division which went out to the printing plant in Wisconsin. As I understand it your Field Studies Division would be receiving a net increase of about three positions; is that right?

Dr. Sencer. I don't think those decisions have been made as yet.

Mr. Obey. How can you submit the budget if they haven't been made?

Dr. Sencer. We don't develop our budget necessarily on a division line, we develop it on a programmatic line because many of the things that would be done, say, in the investigation of the printing industry would be done by both the Laboratory Division and a Field Studies Division. So that we have to make our decisions on a programmatic basis rather than an organizational basis.

Mr. Obey. When will you be able to tell us?

Dr. Sencer. I think when we get the budget and get our reorganization approved.

Mr. Obey. You mean we can't tell before we pass the budget?

Dr. Sencer. We can tell you from a programmatic standpoint.

Mr. Obey. How soon can I find out how many people you are adding to the Field Studies Division?

Dr. Sencer. I can tell you today how we would propose to add personnel in terms of functions, not necessarily in terms of divisions. I have that with me. I could provide that for the record today.

Mr. Obey. Would you do that and then also provide what the numbers would have been for that same function last year?

Dr. **Sencer.** Yes; we have that right here.

Mr. **Obey.** Put it in the record.

[The information follows:]

NIOSH 1974-75 BUDGET BY FUNCTION (PROGRAM AREA)

[Dollars in millions]

Program area	1974		Estimated 1975	
	Positions	Amount	Positions	Amount
A. Surveillance	25	2.0	25	1.8
B. Criteria documentation for standards	30	3.6	54	2.6
C. Laboratory research	84	5.6	84	5.0
D. Laboratory service	101	2.4	102	2.2
E. Field research	21	1.2	21	1.1
F. Technical services	78	2.3	80	2.0
G. Manpower development	32	.9	32	.9
H. Occupational health program	4	4.1	6	1.0
I. Mining (formerly ORD)	84	3.0	87	3.0
J. Research grants	9	3.9	9	2.4
K. Agriculture		.3	3	.8
L. Safety	13	1.2	15	1.2
M. Occupational carcinogenesis	15	1.3	18	1.0
N. Administrative support and policy direction	115	3.6	115	2.9
Total	[1] 611	[2] 35.4	[1] 651	27.9

[1] Includes 9 positions supported from reimbursements.

[2] Includes 1973 funds restored.

NIOSH BUDGET REQUESTS TO OMB

Mr. **Obey.** What was the National Institute for Occupational Safety Health budget request as it came out of the National Institute for Occupational Safety Health before it got up to you or anybody else?

Dr. **Sencer.** $29,865,000 and 660 positions.

Mr. **Obey.** And the budget you are presenting today is?

Dr. **Sencer.** $25,848,000 and 565 positions.

Mr. **Obey.** What was the cut of $4 million for?

Dr. **Sencer.** The Department transmitted a budget of $29,865,000 and 605 positions to the Office of Management and Budget.

Mr. **Obey.** What programs were cut out? What $4 million was cut out?

Dr. **Sencer.** I can't tell you, sir.

Mr. **Obey.** When can you?

Dr. **Sencer.** I have just been told it was in the area of technical assistance, providing assistance to industry and standards setting.

Mr. **Obey.** Can you expand for the record and explain in much more detail specifically what that $4 million request was for, how many positions were eliminated and what kind of work you could have done with that money that you won't be able to do now?

Dr. **Sencer.** Yes, sir.

Mr. **Obey.** What it would have meant in terms of criteria packages proposal to what you can do now?

Dr. **Sencer.** Yes.

[The information follows:]

EFFECT OF $4 MILLION OMB CUT

The 1975 budget request submitted to OMB would have supported 80 new positions and 18 to 20 new starts on criteria document production. Resources now requested will support approximately 14 new starts.

In addition, in response to the acknowledged problems of impact of the Occupational Safety and Health Act on small businesses, the fiscal year 1975 request to OMB would have supported a technical assistance effort to enable industry to comprehend its own problems and provide its own solutions. There are over 5 million workplaces at present, of which approximately 99 percent are considered as small business, and it would, of course, be impossible to provide direct assistance to each; however, by approaching industry-specific problems through a mix of direct assistance and educational and technical assistance aids, it would be possible to prevent many major problems before individual employees are affected or there is a compliance action. We will conduct some activity in support of this strategy in fiscal year 1975 on a pilot type basis.

OUTPUT OF CRITERIA DOCUMENTS

Mr. Obey. How many years at the present rate, Doctor, do you think it would take to provide criteria standards for all of the chemicals and agents people work with?

Dr. Key. There is some professional consensus that the universe toward which we should be striving to develop health standards is approximately 1,000 to 2,000 rather than the many, many thousand named or known chemicals in the environment.

If we get up to a rate of some 50 a year, approximately 20 years.

I should correct something I told you earlier or make it more accurate. The estimate I gave to you for doubling the output of criteria documents was based on continued use of the contract mechanism, and it assumed that the research would also be conducted in order to have the dose-effect information on which one could go ahead and develop a criteria document and recommended standards.

Dr. Sencer. I think there is another limiting factor in this Mr. Obey and that is in the shortage of certain categories of professional personnel, namely toxicologists. This has not been a popular field over the years for people to go into, and we are limited just by the availability of adequately trained professional people.

Mr. Obey. Why isn't it a popular field?

Dr. Sencer. For much the same reason that venereal disease research hasn't been a popular field—there is no big payoff.

Going back into the fifties there have been committees trying to figure out ways to stimulate people to go into toxicology. It is not a glamorous scientific area. It is sort of sitting there with your rats and mice and waiting a long period of time to see what the effect is.

VINYL CHLORIDE

Mr. Obey. What programs and activities are going to have to be dropped Dr. Key, because of your efforts in the vinyl chloride area?

Dr. Key. I have asked the staff for an accounting of this and expect to have the answer within another week.

At this time I think I can say that although the responses for hazard evaluations may be lengthened——

Mr. Obey. By how much?

Dr. Key. I can't quantitate this other than by the same number of weeks that the individuals were working on vinyl chloride.

Mr. Obey. How many people did you have to research?

Dr. Key. For vinyl chloride.

STANDARD FOR ASBESTOS

Mr. **Obey**. On asbestos, it is my impression, and I may be wrong that the standard eventually promulgated was higher than the British standard?

Dr. **Key**. No, sir.

Mr. **Obey**. No, sir, it wasn't or, no, sir, I am not wrong, which?

Dr. **Key**. The British standard was two fibers per cubic centimeter and the U.S. standard initially was five fibers per cubic centimeter with a lowering eventally to two fibers per cubic centimeter.

Mr. **Obey**. So initially it was higher?

Dr. **Key**. That is right. Eventually it will be the same.

Mr. **Obey**. When will it be two?

Dr. **Key**. Four years from initial promulgation, and that was promulgated in 1972.

Mr. **Obey**. That standard, if true, means that is a standard for what, just for the avoiding of asbestosis? It is not a standard for avoiding cancer is it?

Dr. **Key**. In our criteria document recommendation to the Department of Labor I think we used words to the effect that the risk of cancer would be materially lowered at the two fiber cubic centimeter level. We did not guarantee there would be none at this level.

Mr. **Obey**. Am I correct in my understanding that that standard is a standard which is sufficient to avoid a worker contracting asbestosis? Does it have anything to do with cancer, or was it just designed to avoid workers contracting asbestosis?

Dr. **Key**. It was designed to prevent or control both the asbestosis as well as the cancer.

Mr. **Obey**. Let me put it a different way. What percentage of workers could you assume would still contract asbestosis at a level of two fibers?

Dr. **Key**. Very, very small. I can't give you that offhand. I will give you an estimate in the record.

Mr. **Obey**. How about cancer?

Dr. **Key**. I will also give you an estimate of that.

[The information follows:]

ESTIMATE OF ASBESTOSIS AND CANCER BASED ON EXPOSURE TO ASBESTOS FIBERS

The British Occupational Hygiene Society considering the data that were available concluded that an accumulated exposure of 100 fiber-years/cm^3 of air would reduce early clinical signs of asbestosis to less than 1 percent of the workers.

For such workers, who may possibly work for 50 years (the basis for the British standard) the long-term average concentration to which they are exposed would need to be less than 2 fibers/cm^3. For others, who are exposed to asbestos dust in air for shorter periods, the long-term average concentration need not be so low, as long as their exposure will amount to less than 100 fiber-years/cm^3.

Consideration of the shorter working lifetime in the United States of about 30 years as compared to 50 years in the United Kingdom suggests that a U.S. standard of about 3 fibers/cm^3 should assure that less than 1 percent of the workers exposed are at risk of developing the earliest clinical signs of asbestosis.

The British did not consider carcinogenesis in the development of their standard; however, with the recognition that neoplasma, such as mesothelioma may occur without radiological evidence of asbestosis and that the standard must be lower than that required to control asbestosis alone, carcinogenesis was given serious consideration in the development of a U.S. standard. The carcinogenic effect of asbestos is probably not qualifiable in terms of cumulative dose as we really do not know the determinants of cancer, but most researchers would agree that the less exposure the better and certainly that peak exposures should be avoided. The role of cigarette smoking as a co-factor has been well documented.

These considerations were consistent with the findings of the Surgeon General's ad hoc committee on the Evaluation of Low Levels of Environmental Chemical Carcinogens that "for carcinogenic agents, a safe level for man cannot be established by application of our present knowledge."

The recommended U.S. standard was designed primarily to prevent asbestosis. For other diseases associated with asbestos, there is insufficient information to establish a standard to prevent such diseases including asbesto-induced neoplams by any all-inclusive limit other than zero. Nevertheless, a reduction of the standard to 2 fibers/cm^3 will reduce the total body burden and should more adequately guard against neoplasms.

Mr. OBEY. Let me ask you what would happen in your shop if you had another episode similar to the vinyl chloride say tomorrow? Say you had scares in two or three other areas. Your budget wouldn't be nearly adequate to handle it, would it?

Dr. KEY. We have been fortunate in being able to call on the resources of the Center for Disease Control, especially the medical resources. Their Epidemic Intelligence Service officers have been assisting us on vinyl chloride, and I think we could rely on further help from them in this area. We do have our own staff of industrial hygienists and we could pull them off ongoing work for this.

Mr. OBEY. That is my point. Every time you have to divert your people from your long range projects to handle the short range emergency situations you are kind of messing things up on the other end, aren't you?

Dr. SENCER. Mr. Obey, I am not as familiar with the workings of NIOSH as I wish I were. I am being serious now, I am not just trying to defend it.

All of our resources are built to both be responsive to immediate needs and have a continuity of function. For example, not long ago there was a sudden recognition there was a lot of lead getting into the environment from a smelter in El Paso. EPA asked us to help. We had epidemiologists in the field, we were doing the laboratory work, and we were still able to continue our proficiency testing for lead. I think we would work with Dr. Key to find ways we could accommodate to the sudden outbreaks. This is part of our way of life in disease control.

Mr. OBEY. As Dr. Key indicated before, your other programs do suffer when you have to divert people.

Dr. SENCER. This is part of the problem of setting priorities.

Mr. OBEY. I understand it. I am not objecting to doing it. My point is when you have such a minimal amount of the work force covered now by standards, it seems to me this budget is totally inadequate and that you would be in a much more comfortable position if you were up here defending the budget you originally submitted to Office of Management and Budget. I would even have doubts about the adequacy of that budget given the magnitude of the problem.

I understand neither of you gentlemen are responsible for that problem. I understand it is always with OMB. They can find a lot of dollars for other things, but it is almost as though they view progress in this area as being expendable.

I think that is all the questions I have. I think we covered the rest yesterday.

VENEREAL DISEASE

Mr. CONTE. Will you give some examples of your programs to get information on venereal disease to young people?

Dr. Sencer. Through cooperation with Operation Venus, the national VD "hotline" and similar metropolitan "hotlines," we help bring consultation and referral services to many thousands of young people with venereal disease problems. Close working ties between official health agencies and such youth-centered organizations as free clinics are encouraged through the grant program. We assist in the development, improvement, and implementation of ways of teaching young people about venereal disease in both formal classroom and informal community settings. We are working with the Boy Scouts in teaching their membership about venereal disease and getting their members involved in community venereal disease educational programs. Intermittently, we work with State youth conferences and with such organizations as the Student American Medical Association and Student American Pharmaceutical Association in localized programs. Venereal disease "counterattacks," patterned after the community campaigns of such organizations as the March of Dimes, but where information is given rather than money collected, are expected to involve hundreds of thousands of youth volunteers.

Mr. Conte. What age groups, and other special populations, show the greatest increase in venereal disease?

Dr. Sencer. Populations at greatest risk of acquiring gonorrhea are teenagers and young adults between the ages of 15–29. Gonorrhea cases among persons 15–19 years of age increased 281.4 percent; among persons 20–24 years of age, cases increased 254.2 percent; and among persons 25–29, cases increased 164.0 percent during the period of time 1960–72.

The highest reported case rates have been in males, but in 1972, reported cases of gonorrhea among females increased 36.3 percent while among males cases increased only 2 percent. We believe this reflects the emphasis placed on finding and treating asymptomatic females since the implementation of a major gonorrhea control effort began in 1972.

The populations at greatest risk for acquring syphilis are teenagers and young adults between the ages of 15–29. Reported cases of infectious syphilis increased 56.6 percent in the 15–19 age group, 54.8 percent in the 20–24 age group, and 42 percent in the 25–29 age group during the period of 1960–72. Because symptoms are less noticeable in females, and more difficult to detect, reported cases are highest among males.

For both gonorrhea and infectious syphilis, rates per 100,000 population are highest in large cities (200,000 or more population), and lowest in small towns and rural areas. As I mentioned in my prepared statement reported data for this year show improvements.

LEAD POISONING

Mr. Conte. How many children do you expect to screen for blood lead level in 1974?

Dr. Sencer. We expect 300,000 children will be screened by grantees in local control programs during fiscal year 1974.

Mr. Conte. How many laboratories are capable of doing blood lead level tests?

Dr. SENCER. We do not know of every laboratory in the country now performing blood lead testing. Of those which are participating in our proficiency monitoring program, about 30 demonstrate the capability to perform accurate blood lead analysis.

Mr. CONTE. FDA was doing tests, last year, of tolerable levels in lead in multiple layers of paint. Was the Center involved in that testing, and what were the results?

Dr. SENCER. The Food and Drug Administration, in cooperation with the National Bureau of Standards, has carried out testing of methods to identify lead in multiple layers of paint. The Center for Disease Control was not directly involved in this testing. To date, a standardized method of testing for lead in multiple layers of paint has not been developed.

Mr. CONTE. Have you done away completely with training classes for State laboratory personnel?

Dr. SENCER. No. Our current laboratory training emphasis is directed toward assisting States to conduct their own laboratory training courses. Assistance is provided in the form of technical assistance in the design and conduct of courses and provision of training materials including manuals and cultures and the loan of some difficult-to-obtain equipment. In addition, we are still presenting headquarter courses for State laboratory personnel in areas of particular public health importance. These areas include but are not limited to the detection of hepatitis-associated antigen, detection of drugs of abuse, and the laboratory diagnosis of toxoplasmosia, rubella, cytomegalovirus, and herpes. The effective detection of this latter group is essential to our success in reducing the number of preventable birth defects in the Nation.

The overriding concern in all our training activities is to achieve the multiplier effect by training individuals such as supervisors who will transmit the skills and techniques acquired at the CDC to other laboratory personnel.

DRUG ABUSE

Mr. CONTE. Have there been any major recent advances in testing technology to determine narcotic drug abuse?

Dr. SENCER. There have been no major advances in technology to determine narcotic drug abuse. Therefore, the Center has placed emphasis on refining existing methods and training. Laboratory identification and analysis of biologic fluids for drugs of abuse is a field of quite diverse methods and a great range of quality. CDC is working on the refinement and standardization of these methods. Available technologies, that is, thin layer chromatography, gas liquid chromatography, spectrophotometry and spectrofluorometry, are sophisticated analytical procedures which require extensive sample preparation and procedural standardization including the use of controls and standards. Improvement of laboratory performance in the analysis of alcohol and other abused drugs has been supported for the past 3 years in a demonstration self-evaluation program for clinical laboratories and by a continuing proficiency testing program in urinary drug identification for public health laboratories and those in interstate commerce as well as all federally funded methadone treatment centers.

FEDERAL HEALTH EDUCATION EXPENDITURES

Mr. CONTE. Do you have a figure for the total Federal health education expenditure?

Dr. SENCER. We do not have a reliable figure for the Government as a whole. The President's committee estimated that $30 million is spent in HEW.

Mr. CONTE. What is going to be the Center's health education role in the HMO program?

Dr. SENCER. CDC would offer professional expertise to HMO and all other programs, and would try to facilitate interagency collaborative activities. The HEW Health Education Board would review priorities and policies in all major health education activities, including HMO's.

DRUG EDUCATION PROGRAMS

Mr. CONTE. Do you have any responsibilities for drug education programs?

Dr. SENCER. As with HMO's, we would have a facilitation role rather than direct responsibilities in drug education. Each agency retains responsibility for its own educational programs, within policies and guidelines that will be established by the HEW Board.

SALMONELLA

Mr. CONTE. How do you and FDA share responsibility in a case like the 1973 Christmas candy Salmonella case?

Dr. SENCER. CDC has responsibility for maintaining surveillance on human disease and for providing epidemic aid upon request. The FDA has legal responsibility with respect to the purity and safety of food products. This outbreak came to our attention on January 17–18, as a consequence of our routine surveillance of salmonellosis in the United States. *Salmonella eastbourne*, a previously rare serotype, was noted in increasing numbers during January in the weekly surveillance reports we receive from each State. On January 27, with the assistance of eight State health departments that had reported cases, we prepared a list of 15 products that were suspect as causes of illness. CDC proposed that each case be queried promptly about his exposure to each item on this list, and that age-matched neighbor controls be similarly queried. This investigation incriminated foil-wrapped chocolate balls as the vehicle of infection in this outbreak. This epidemiological association was substantiated on January 31, by the demonstration of *S. eastbourne* in chocolate balls by the New Jersey Health Department Laboratory. Because a food product was involved, FDA was kept fully apprised of our findings throughout this phase of the investigation and contributed to the investigation by tracing the distribution of candy that patients had consumed back to the wholesalers and ultimately to the manufacturer in Quebec, Canada. On February 1, FDA announced the voluntary recall of the chocolate candy by the manufacturer. By monitoring disease occurring in the population, the Center identified this special problem with salmonellosis. Having traced the source of infection to a food product, we began to work with FDA which has regulatory authority and responsibility.

SMOKING EDUCATION PROGRAMS

Mr. CONTE. Do you have any special smoking education programs for young people?

Dr. SENCER. The general objective of the Clearinghouse is to reduce the death and disability that results from the use of tobacco. To accomplish this it is essential to encourage young people not to take up smoking and to decrease the proportion of adolescents who take up cigarette smoking and become confirmed smokers. The Clearinghouse has developed, and is developing, educational materials appropriate for both nonsmoking teenagers and those who have already begun to smoke. The information is disseminated through all available channels—the media, schools, private and voluntary organizations, community sources, et cetera. Recent Clearinghouse projects include a special self-test for teenagers to help them develop insights into their knowledge and attitudes on the smoking problem and to make informed decisions with respect to it. Another innovative Clearinghouse program is a school curriculum project in which teachers of fifth, sixth, and seventh grades are given special training in courses to help boys and girls make wise decisions about the protection and care of their bodies. The children learn not only what makes their bodies function but how common risk factors in daily life, and misuse of food, exercise, stress, alcohol, tobacco, and drugs can impair their health.

Mr. CONTE. Is smoking increasing among the young? How many young people are taking up smoking only for a short time and how many go on to heavy smoking?

Dr. SENCER. As to smoking behavior among youth, there has been fairly little overall change in the proportion of young people (ages 12 to 18) who smoke. There has been a trend toward a decrease in the proportion of boys smoking and an increase in the proportion of girls smoking. They are now smoking at about the same rate—between 15 and 16 percent.

By the time a young person has reached the age of 18, it is very likely that he has at least experimented with cigarettes (between 80 and 90 percent). At the present time approximately 33 percent of 18-year-old boys and 28 percent of 18-year-old girls report that they are smoking cigarettes on a regular basis.

ARCTIC RESEARCH CENTER

Mr. CONTE. I gather you've closed that Arctic Research Center. What happened to the facilities? Isn't that closing going to be reconsidered in view of the coming influx of workers into an environment that poses special working and health conditions?

Dr. SENCER. The facilities were transferred to the University of Alaska. The health problems associated with any influx of workers as a result of the pipeline construction would, in all likelihood, pose immediate demands on the health care delivery system. The Arctic Health Research Center was engaged primarily in long-term research on health in the Arctic.

NATIONAL CLEARINGHOUSE FOR SMOKING AND HEALTH

Mr. NATCHER. There has been growing concern about a conflict of interest in the National Clearinghouse for Smoking and Health. On the one hand it is conducting antismoking activities. On the other it is providing Congress with what is supposed to be an objective review of the scientific literature relating to smoking and health. It appears to be acting as both prosecutor and judge. The former Surgeon General, Dr. Steinfeld, agreed that this criticism was an excellent point and we should look into the association of those two functions within HEW. What is your own view?

Dr. SENCER. The Public Health Cigarette Smoking Act of 1969 requires the Secretary to submit to the Congress each year a report on the health consequences of smoking. The responsibility for preparing this report has been given to the Clearinghouse for Smoking and Health, in the Center for Disease Control, since this is the agency which collects and reviews scientific information in the field.

The reports to Congress are based on the assessment of all available scientific information and are prepared under procedures which have been approved by the Department. The clearinghouse director and staff physicians submit research studies gathered from all parts of the world to outstanding experts in scientific and technical fields for their evaluation. Included in studies for review are those which present data inconsistent with the established relationships between smoking and disease. These studies, like the overwhelming number of studies which support and strengthen the evidence linking smoking with disease, are carefully considered and evaluated and cited in the report.

The physicians and scientists who review the studies (some of whom, incidentally, have been associated with research projects financed by the tobacco industry) are completely independent of the clearinghouse antismoking educational activities. The evaluations of the research returned by the reviewers are in turn reviewed by the Department and by all other interested agencies in the Department, including the National Institutes of Health.

When the report is transmitted to Congress it represents the views and positions of the Secretary and the Department.

AGRICULTURAL INSECTICIDES

Mr. ROBINSON. OSHA, and more recently EPA have issued proposed standards for the reentry of workers into fields and orchards or groves sprayed with certain agricultural insecticides. This indicates a further interest in agriculture with respect to these two agencies. On page 125 of your justification, you mention research in parathion as being one of your 1974 projects and yet, on page 126, you refer to work on the environment of all nonagricultural industries. What is the interest and expertise within NIOSH with respect to agriculture? EPA and OSHA had a cooperative arrangement with regard to hearings which they held when they were gathering data for their reentry standards. Did NIOSH participate in these hearings?.

Dr. KEY. NIOSH responsibilities for research and development of recommended standards parallel the enforcement responsibilities of OSHA. It should be pointed out that the NIOSH criteria document for parathion will apply to the manufacturing, formulation, and application of this insecticide. The document was developed by contract, and is being reviewed by professionals in NIOSH and other organizations. NIOSH participated in OSH–EPA regional hearings and presented testimony on August 22, 1973, in Washington, D. C. NIOSH has a considerable interest in agricultural safety and health and has a small, but highly competent, nucleus of professionals who have already initiated a program in this area. NIOSH and CDC are in the process of developing a memorandum of understanding with EPA on the subject of pesticides research.

OCCUPATIONAL SAFETY AND HEALTH IN AGRICULTURE

Mr. Robinson. On page 8 of your statement you refer to the fact that NIOSH conducts surveillance of occupational illnesses and accidents. One of our problems regarding occupational safety and health in agriculture has been a lack of accurate statistical evidence with respect to this area. Are you making any effort to accumulate statistics in agriculture or is your surveillance merely one of looking into those accidents that are brought to your attention?

Dr. Key. We agree that the lack of statistical information on the hazards in the agricultural area is a handicap to developing an effective strategy in this area, and we have placed high priority in establishing a better information system. To this end we have scheduled a meeting with the National Safety Council to explore the development of a joint data gathering system based upon the 10 State survey program on agricultural injuries carried out by the National Safety Council. By including in the survey program health concerns as well as safety, we believe that we will be able to obtain the kind of information that is needed.

TECHNICAL ASSISTANCE AND INFORMATION

Mr. Robinson. What is the extent of your being able to provide technical assistance and information through your field stations and regulatory offices? I have in mind a northern New York Congressman with a problem regarding to the fact that talc has evidently been put into the same category as asbestos in terms of being dangerous to workers even though it is quite different in characteristics and is nonfibrous. Congressman McEwen tells me that a contact with your office to try to resolve this problem did not result in any technical assistance. Would you comment?

Dr. Key. The NIOSH headquarters operation in Rockville as well as our field stations in Cincinnati, Morgantown, and Salt Lake City are staffed with individuals possessing a high level of technical expertise in the area of occupational safety and health. All of our technically oriented divisions and offices, and in patricular those located in field stations, are frequently called on to provide technical assistance on a variety of matters such as tremolitic talc.

In 1973, in response to a request for assistance from OSHA, NIOSH reviewed a petition regarding tremolite from R. T. Vanderbilt Co., Inc., and International Talc Co. Congressman McEwen expressed his concern in this matter to OSHA, who referred it to NIOSH. The petition was reviewed in light of the existing OSHA standards with the resultant recommendation that the petition be denied.

The problem revolves around the correctness of an existing Federal standard promulgated and enforced by the Occupational Safety and Health Administration, DOL. In response to a recent request from OSHA we have scheduled a meeting for mid-April of this year at which time this matter will be completely reviewed by NIOSH personnel and consultants, and resultant recommendations will be forwarded to OSHA.

POTENTIALLY TOXIC SUBSTANCE

Mr. SHRIVER. Under the National Institute for Occupational Safety and Health, which is also included in this request, one of the functions is to respond to requests from employers and employees for health and safety hazard evaluation. Tell us more about what assistance is available in the form of information and advice. Is this just for large employers, or could a small businessman come to you for advice?

Dr. SENCER. The National Institute for Occupational Safety and Health is responsible for the health hazard evaluation program mandated by section 20(a)(6) of the Occupational Safety and Health Act and defined by regulations in 42 CFR, part 85. The program is charged with the responsibility of determining whether any substance normally found in the place of employment has potentially toxic effects at the concentrations used or found, specifically for small businesses.

In addition to the hazard evaluation program, the National Institute for Occupational Safety and Health has established a pilot consultative services program to assist small businessmen in complying with the act. We provide direct onsite safety industrial hygiene investigations, primarily in selected industries in order to extend our very limited manpower. From the knowledge acquired in these investigations, we plan to produce information packets detailing commonly encountered health and safety problems and disseminate this information to as many small businesses as possible.

In addition to these activities, the National Institute for Occupational Safety and Health responds annually to thousands of written and telephone requests on technical matters and provides direct onsite industrial hygiene and medical investigations upon request from employers or employees.

RAT CONTROL PROGRAM

Mr. SHRIVER. Once you have brought local rat control programs to the maintenance level, are all of the costs taken over the local governments? I believe the justifications mention that they pay about 45 percent of the costs up to the point of maintenance.

Dr. SENCER. Project grants for urban rat control are provided, initially, on an annual basis for a period not to exceed 5 years. Continuation grants after the first year are made on the basis of satisfactory progress toward attaining maintenance level in the target area.

Deduction of Federal funds by 10–15 percent per year is recommended during the third, fourth, and fifth years, with the expectation of increased support by State and local agencies. It is expected that the project will reach a maintenance level in the target area within 5 years.

At the completion of the 5-year period, an annual maintenance grant can be awarded for a maximum period of 3 additional years. This maintenance grant may not exceed 50 percent of the fifth year funding except for good cause shown.

In fiscal year 1969, projects assumed 27 percent—$5,504,045—of total costs—$20,523,451—of rat control programs. In fiscal year 1973, projects assumed 45 percent—$12,202,477—of total costs—$26,927,727—of the programs. In two project cities in New York State, total financial support for urban rat control was assumed by local funding in fiscal year 1974—Binghamton through a 50-50 State aid program, and Poughkeepsie through the local county health department.

NEW POSITIONS FOR OCCUPATIONAL SAFETY AND HEALTH

Mr. Shriver. You are requesting an increase of 40 positions to change over some of your occupational safety and health activities from a contract basis to an in-house basis. Why do you feel this changeover is necessary? Is it less expensive or more expensive to do the work in-house?

Dr. Sencer. In addition to the fact that in-house resources are required to initiate and manage a contract effort such as we already have underway, I feel it is necessary to maintain a balanced program with a reasonable level of in-house effort on the part of the Institute so that we can effectively utilize the results of research conducted extramurally. It is difficult to make a general cost comparison since, quite obviously, contracts are normally with profitmaking organizations.

IMMUNIZATION PROGRAM

Mr. Shriver. You show a program decrease of $4,450,000 because of a nonrecurring program to improve immunization programs against diseases susceptible to vaccination control. You have accomplished your purpose in this, is that right? Tell us about that.

Dr. Sencer. We believe that the level of funding requested for fiscal year 1975 will be adequate to continue the progress which is being made in reducing the incidence of rubella, measles, diphtheria, tetanus, and pertussia. The $4,450,000 which was available in fiscal year 1974 has helped to replenish vaccine supplies, and has insured the availability of adequate supplies to meet the needs of intensive immunization campaigns which are being carried out in fiscal year 1974-75. Reported measles cases are declining for the third straight year and the rubella epidemic expected in 1970-72 has still not occurred.

LEAD POISONING

Mr. Shriver. The same goes for the decrease of $4,500,000 because of a nonrecurring program to strengthen capabilities of State health laboratories in regard to blood-lead analyses. This is part of the leaded paint program, I assume. Tell us what has been accomplished by this one-shot program.

Dr. SENCER. This money has just recently been made available and grants have not yet been made to State laboratories. After the grants are made, we expect the capability for accurate blood-lead analyses in the United States to increase considerably. Local prevention programs will be spared the expense of setting up their own laboratories, and one of the major roadblocks to implementation of screening under medicaid will be removed. We expect that other sources of funding, including medicaid reimbursement, can sustain the operation of these laboratories once we have helped in getting them establisehed.

Mr. SHRIVER. On page 110 of the justifications it is stated that your immunization efforts in 1975 will concentrate on determining groups in our country with low immunity levels, and on redesigning your immunization programs to close the gap between central city and noncentral city immunity levels. What do you have planned in this regard?

Dr. SENCER. Effective systems of assessment to define the areas with the largest proportion of inadequately protected children are now operational in several States and cities. We plan to expand these systems to additional communities. Data are collected from immunization level surveys of children at school entry, day care centers, Head Start programs, and random sample surveys of selected groupings of 2-year-old children. This information enables health departments to identify areas of greatest need. When indicated, "mini" immunization campaigns will be aimed at these specific groups.

BUBONIC PLAGUE

Mr. SHRIVER. Are you still supporting investigation and control of plague? To what extent is this still a problem in this country?

Dr. SENCER. Bubonic plague creates four basic types of control problems in the United States.

1. Sylvatic plague maintained in a wild rodent flea-transmission cycle is still widespread in 17 Western States and offers a constant threat of human exposure, particularly in outdoor recreation areas.

2. There is a constant threat of invasion of urban communities from the above sylvatic sources of infection, for example, three squirrels in Denver, Colo., in 1968 and domestic rats in Tacoma, Wash., in 1971.

3. There is a constant threat of introduction of exotic strains of plague from countries such as Vietnam and Indonesia by way of international air and sea traffic.

4. An outbreak of plague in any shipping port such as Los Angeles, San Francisco, or Seattle would require closing down of the port under International Sanitary Regulations with subsequent loss of millions of dollars.

The above control problems have been complicated during recent years by environmental regulations reducing or eliminating the use of rodenticides. This has resulted in the resurgence of rodent populations with an increased threat of epizootic plague. In the past 5 years, there have been 23 cases of human plague in the United States which is several times the incidents reported during the past half century.

Given the nature of the above problem CDC provides assistance and consultation to Federal, State and foreign governments on laboratory diagnosis, surveillance techniques, epidemiologic investigation, and prevention and control of bubonic plague. The Center's Plague Laboratory functions as the Western Hemisphere Reference Center for plague and provides standardized laboratory techniques, training, and reagents to U.S. agencies, WHO, and PAHO, and conducts research on the ecology and control of plague. This includes development of improved laboratory and diagnostic techniques, and new insecticidal, rodenticidal, immunization and ecological management systems for plague prevention and control. CDC has the only laboratory in the United States capable of providing these services.

INTERNATIONAL HEALTH REGULATION

Mr. **Shriver.** On page 115 you state that you will be looking at possible modifications of requirements relative to the International Health Regulations. Does this mean changes in the types of shots required and things like that? Tell us more about that.

Dr. **Sencer.** In accordance with article 54 of the World Health Organization's International Health Regulations, the Center continues to perform rodent infestation inspections for the issuance of deratting/deratting exemption certificates. The scope of inspection and issuance of certificates is within the capabilities of private enterprise. We are exploring alternatives for providing services through the private sector.

Inspection efforts at ports of entry are directed to identifying travelers whose itinerary and vaccination status or illness is consistent with the possibilities of a smallpox importation. Arriving persons are evaluated (by flight) regarding itinerary (presence of smallpox-infected country) and frequency with which they are unvaccinated or ill upon arrival. Based on this information and knowledge of worldwide disease conditions assignment of manpower is focused at those locations and during times when high-risk flights arrive.

LABORATORY SERVICES

Mr. **Shriver.** You say on page 118 that a combination of circumstances has created a "unique" opportunity for the Center to play a leading role in the improvement of national health laboratory services. That is discussed at some length in the book, but would you comment on it briefly now?

Dr. **Sencer.** Since 1966, laboratory quality standards under the Clinical Laboratories Improvement Act for medicare and, more recently, the regulations issued by the FDA for controlling in vitro diagnostic products, have made possible the development and consensus acceptance of standards of performance previously difficult or impossible to achieve.

Laboratory improvement can be accomplished only when acceptable basic laboratory technology is developed in three areas: Analytical methods, quality calibration and control materials, and means of quality assessment and control. Research and development in any one of these areas requires parallel development in the other two.

If the goals of the laboratory improvement programs are to be attained in each of the more than 12,000 health laboratories of the

Nation, the basic technologies must be efficiently and effectively learned and practiced in each laboratory. CDC's national laboratory improvement program is the focal point for a coordinated attack upon the recognized health laboratory problems. The important consideration here is that cooperation with the FDA in the area of product class standards for in vitro diagnostic products and cooperation with the Social Security Administration in the application of equal standards for all medicare laboratories, will allow us to have a positive influence on the services provided by practically all of the Nation's health laboratories.

HAZARDOUS SUBSTANCES

Mr. **Shriver.** In conclusion, I have one general question. It seems like every day there is a report in the media concerning possible hazards to people from a large variety of products and materials. These reports are all based on scientific evidence, yet later there may be reports to the contrary, also supposedly based on scientific evidence.

What is your view of the proper role of Government in attempting to interpret these scientific reports to the public? Should the Government actually intervene, say to limit by regulation the use of such products? If so, in some cases, what then should the Government's action be when conflicting reports are offered by the scientific community?

Wouldn't it be far better in most cases to allow all this information be made available to the public and let them, perhaps in consultation with their personal physician, make up their own minds concerning the use of products in their personal lives?

Dr. **Sencer.** The evaluation of possible hazards is very complex and difficult because of the usual paucity of "scientific" evidence which is generally found for evaluation purposes. Such evidence as may be available may be biased in its development or its selection, even by well-meaning researchers. In hazard evaluation, the objective is to acquire all information that is available to examine and evaluate that data candidly and provide an objective report on the findings of the study.

The role of the Government in this evaluation process should be to provide that objectivity which is necessary to protect the public from injurious products and to protect industry from needless precautions. To insure this objectivity, acquisition, and development of information, selection of the people to review the evidence, and monitoring the review process become the most important governmental responsibility. The review process must evaluate the completeness of the information found, the quality of information available, and the accuracy of interpretation. The review process would also indicate what additional information must be developed for a valid appraisal of the hazard.

Obviously, all hazards cannot be evaluated in this manner in a timely fashion. There must be some priority to the selection of hazards which can be evaluated with this in-depth objectivity. This priority setting activity can be set only by governmental objectivity. In order that hazards considered to be of lesser importance can be handled, such information as is available must be made available to the public so that industry and the using public can make their own appraisal of the evidence. While public evaluation will handle some of the more obvious problems associated with the use of some items with hazards, the public is unable to cope with the more subtle effects from less obvious hazards such as the effects of carcinogens, high frequency ovens, glue solvents, and more. Most physicians in private practice are not aware of the nature of the problems that may be presented to them and usually do not have the necessary information available to make correct evaluation. Use of public self-policing cannot control such hazards and is not likely to be aware of such hazards without an active evaluation program carried on by the Government to stimulate active research and publicize the results.

Mr. OBEY. Thank you very much. We will adjourn until 2 p.m. Monday.

JUSTIFICATION OF THE BUDGET ESTIMATES

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
CENTER FOR DISEASE CONTROL

Preventive Health Services

Amounts Available for Obligation

	1974 Revised	1975
Appropriation	$134,565,000	$137,814,000
Proposed supplemental for pay increases	1,789,000	---
Subtotal, adjusted appropriation	136,354,000	137,814,000
Real transfer to:		
"Departmental management" For Department-wide Public Affairs reduction.	-112,000	---
Comparative transfers to:		
"Departmental management" To remove certain reporting activities from the Department Working Capital Fund and to support an ADP Management System in the Secretary's Office of Public Affairs.	-16,000	---
"Office of the Assistant Secretary for Health" Transfer of administrative support activities to the Office of Assistant Secretary for Health.	-108,000	---
"Mental Health" Support of Federal Employee Alcoholism Program.	-14,000	---
Comparative transfers from:		
"Departmental management" Decentralization of indirect cost function from Department Working Capital Fund.	+16,000	---
"Office of the Assistant Secretary for Health" Decentralization of Commissioned Officers personnel servicing from Service and Supply Fund.	+73,000	---
Subtotal, budget authority	136,193,000	137,814,000

Amounts Available for Obligation - continued 1/

	1974 Revised	1975
Unobligated balance, start of year	---	1,964,000
Unobligated balance, transferred from other accounts	1,964,000	---
Unobligated balance, end of year	-1,964,000	-1,000,000
Subtotal, 1974 base obligations	136,193,000	138,778,000
Unobligated balance - restored	15,982,000	---
Total, obligations	152,175,000	138,778,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1974 - $8,330,000; 1975 - $8,330,000.

Summary of Changes

1974 Estimated obligations	$152,175,000
1975 Estimated obligations	138,778,000
Net change	-13,397,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of 1974 pay raises	---	---	---	+$1,561,000
2. Extra day of pay	---	---	---	+124,000
3. BEC increase...............	---	---	---	+21,000
4. Increased DHEW working capital fund	---	---	---	+68,000
5. Payment to GSA for rent.....	---	---	---	+3,413,000
Subtotal....			---	+5,187,000
B. Program:				
1. Disease control - Disease investigations, surveillance, & control	1,495	$39,657,000	+10	+130,000
2. Disease control - Laboratory improvement	459	9,832,000	+10	+120,000
3. Health education	36	3,206,000	---	+1,250,000
4. Occupational health - Direct operations	525	29,526,000	+40	---
5. Buildings and facilities ...	---	---	---	+964,000
Subtotal....			+60	+2,464,000
Total, increases				+7,651,000
Decreases:				
A. Built-in:				
1. Disease control - Laboratory improvement	---	---	---	-120,000
Subtotal....			---	-120,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Decreases cont'd:				
B. Program:				
1. Disease control - Project grants Infectious diseases	657	$35,450,000	---	-$4,450,000
2. Disease control - Project grants Lead-based paint poisoning in children	10	11,000,000	---	-4,500,000
3. Disease control - Disease investigations, surveilance, and control......	1,495	39,657,000	---	-967,000
4. Disease control - Laboratory improvement	459	9,832,000	---	-1,305,000
5. Disease control - Health education...........	36	3,206,000	---	-1,470,000
6. Occupational health - Grants	---	3,764,000	---	-1,512,000
7. Occupational health - Direct operations..........	525	29,526,000	---	-6,231,000
8. Program management - Program direction	174	4,257,000	---	-351,000
9. Program management - Regional offices	92	2,383,000	---	-142,000
Subtotal			---	-20,928,000
Total, decreases			---	-21,048,000
Total, net change			+60	-13,397,000

Explanation of Changes

Increases:

A. Built-in:

An increase of $5.187,000 includes $1,561,000 for annualization of pay raises in 1974, $124,000 for one extra day of pay, $21,000 for Bureau of Employee Compensation, $68,000 for DHEW working capital fund, and $3,413,000 for payment to GSA for building space rent.

B. Program:

1. Disease control - Disease investigations, surveillance and control

An increase of $130,000 and 10 positions to support expanded research and development to further refine and implement surveillance methods and analytic techniques in the National Nosocomial Infections Study, surveillance of hospital-acquired infections, and evaluation of control measures.

Explanation of Changes (Continued)

2. Disease control - Laboratory improvement

An increase o $120,000 and 10 positions to extend the application of the high standards of the Clinical Laboratories Improvement Act of 1967 to more of the nation's clinical laboratories at a faster rate.

3. Disease control - Health education

An increase of $1,250,000 for first full year operation of a national health education program.

4. Occupational health - Direct operations

An increase of 40 positions to provide for further in-house development of criteria for standards in occupational safety and health, previously funded by contract.

5. Buildings and facilities

An increase of $964,000 for repair and maintenance of the Center's facilities. Funds for this activity will be transferred from funds appropriated in the HSMHA Buildings and Facilities appropriation in previous years and will remain available in this appropriation until obligated. No new budget authority is being requested.

Decreases:

A. Built-in:

1. Disease control - Laboratory improvement

A decrease of $120,000 results from nonrecurring purchases of equipment.

B. Program:

1. Disease control - Project grants - Infectious diseases

A decrease of $4,450,000 results from a nonrecurring program effort in 1974 to enhance support of immunization programs against diseases susceptible to vaccination control, particularly by replenishing supplies of vaccine. This effort was funded by additional project grants to States.

2. Disease control - Project grants - Lead-based paint poisoning in children

A decrease of $4,500,000 results from a nonrecurring program effort in 1974 to strengthen capabilities of State health laboratories to perform sophisticated and accurate blood-lead analyses. This effort was funded by additional project grants.

Explanation of Changes (Continued)

3. Disease control - Disease investigations, surveillance and control

A decrease of $967,000 results from nonrecurring purchases of equipment and closing of the Arctic Health Research Center in 1974.

4. Disease control - Laboratory improvement

A decrease of $1,305,000 results from nonrecurring program costs in 1974 to support a national conference on quality control in public health laboratories and for purchases of bulk laboratory material for proficiency testing.

5. Disease control - Health education

A decrease of $1,470,000 results from nonrecurring program costs in 1974 for nutrition and chronic diseases.

6. Occupational health - Grants

A decrease of $1,512,000 results from nonrecurring research and training grants made available in 1974.

7. Occupational health - Direct operations

The decrease of $6,231,000 includes $3,582,000 due to a nonrecurring program effort in 1974 to improve and make the occupational respiratory disease clinics for coal miners self-sufficient, and $2,649,000 due to nonrecurring research contracts for the development of analytical procedures for detection of carcinogens and to supplement criteria standards development.

8. Program management - Program direction

The decrease of $351,000 results from annualization of savings from reduction of positions in 1974.

9. Program management - Regional offices

A decrease of $142,000 results from completion in 1974 of the two-year National Occupational Hazard Survey to develop basic descriptive information on the working environment of nonagricultural industries covered under the Occupational Safety and Health Act.

Explanation of Changes (by activity)

A. Disease control - Disease investigations, surveillance, and control.

Built-in increases of $1,229,000 for annualization of pay raises in 1974, one extra day of pay, Bureau of Employee Compensation, and DHEW working capital fund; program increase of $130,000 and 10 positions to support expanded research and development to further refine and implement surveillance methods and analytic techniques in the National Nosocomial Infections Study; and program decrease of $967,000 resulting from nonrecurring purchases of equipment and closing of the Arctic Health Research Center.

B. Disease control - Laboratory improvement.

Built-in increase of $141,000 for annualization of pay raises in 1974, program increase of $120,000 and 10 positions to extend the application of the high standards of the Clinical Laboratories Improvement Act of 1967 to more of the Nation's clinical laboratories at a faster rate and program decrease of $120,000 for nonrecurring equipment purchased in 1974.

C. Disease control - Health education.

Built-in increase of $44,000 for annualization of pay raises in 1974, and program increase of $1,250,000 for first full year operation of a national health education program.

D. Occupational health - Direct operations.

Built-in increases of $301,000 for annualization of pay raises in 1974, and one extra day of pay; program increase of 40 positions to provide for further in-house development of criteria for standards in occupational safety and health, and for further in-house research; and program decrease of $3,582,000 due to the nonrecurring effort in 1974 to improve and make the occupational respiratory disease clinics for coal miners self-sufficient.

E. Buildings and Facilities.

Program increase of $964,000 made available in prior years and transferred from the HSMHA Building and Facilities appropriation, to remain available in this appropriation until obligated.

F. Program management - Program direction.

Built-in increase of $3,413,000 for payment to GSA for building space rental and program decrease of $255,000 resulting from annualization of savings due to reduction of positions in 1974.

G. Program management - Regional Offices.

Built-in increase of $59,000 for annualization of pay raises in 1974, and program decrease of $142,000 due to completion in 1974 of the two-year National Occupational Hazard Survey to develop basic descriptive information on the working environment of nonagricultural industries covered under the Occupational Safety and Health Act.

Obligations by Activity

Page Ref.		1974 Base* Pos.	1974 Base* Amount	1975 Estimate Pos.	1975 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
	Disease control:						
	(a) Project grants						
110	1. Infectious diseases	657	$31,000,000 (35,450,000)	657	$31,000,000	---	---
112	2. Rat control..	---	13,100,000	---	13,100,000	---	---
112	3. Lead-based paint poisoning in children....	10	6,500,000 (11,000,000)	10	6,500,000	---	---
114	(b) Disease investigations surveillance, & control.........	1,495	39,657,000	1,505	40,049,000	+10	+$392,000 A
118	(c) Laboratory improvement.....	459	8,527,000 (9,832,000)	469	8,668,000	+10	+141,000 B
122	(d) Health education.	36	1,736,000 (3,206,000)	36	3,030,000	---	+1,294,000 C
	Occupational health:						
124	(a) Grants	---	2,252,000 (3,764,000)	---	2,252,000	---	---
124	(b) Direct operations	525	26,877,000 (29,526,000)	565	23,596,000	+40	-3,281,000 D
127	Buildings and facilities .... Budget authority...	---	--- [---]	---	964,000 [---]	---	+964,000 E [---]
	Program management:						
128	(a) Program direction	174	4,161,000 (4,257,000)	174	7,319,000	---	+3,158,000 F
129	(b) Regional offices	92	2,383,000	92	2,300,000	---	-83,000 G
	Total obligations....	3,448	136,193,000 (152,175,000)	3,508	138,778,000	+60	+2,585,000

*1974 Base - Excludes 1973 appropriation restorations. Total obligations are shown in parenthesis.

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Total number of permanent positions	3,448	3,508	+60
Full-time equivalent of all other positions	154	154	---
Average number of all employees	3,556	3,601	+45
Personnel compensation:			
Permanent positions	$48,261,000	$49,455,000	+$1,194,000
Positions other than permanent	1,078,000	1,078,000	---
Other personnel compensation	1,192,000	1,192,000	---
Subtotal, personnel compensation	50,531,000	51,725,000	+1,194,000
Personnel benefits	5,632,000	5,733,000	+101,000
Benefits of former personnel ...	72,000	---	-72,000
Travel and transportation of persons	3,510,000	3,513,000	+3,000
Transportation of things	733,000	733,000	---
Rent, communications and utilities	3,694,000	6,940,000	+3,246,000
Printing and reproduction	914,000	997,000	+83,000
Other services	5,707,000	6,344,000	+637,000
Project contracts	19,148,000	11,046,000	-8,102,000
Supplies and materials	4,184,000	4,159,000	-25,000
Equipment	2,129,000	2,129,000	---
Lands and structures	8,000	8,000	---
Grants, subsidies and contributions................	55,915,000	45,453,000	-10,462,000
Subtotal	152,177,000	138,780,000	-13,397,000

Obligations by Object - continued

	1974 Estimate	1975 Estimate	Increase or Decrease
Less quarters and subsistence direct	-2,000	-2,000	---
Total obligations by object	152,175,000	138,778,000	-13,397,000
Total, 1974 base obligations	(136,193,000)	(138,778,000)	(+2,585,000)

Authorizing Legislation

Legislation	1975 Authorization	1975 Appropriation Requested
Preventive Health Services Activity:		
Disease control		
Project Grants		
Sections 317(d)(2) and (3) of the Public Health Service Act.	$29,000,000	$6,200,000
Section 318(d)(2) of the Public Health Service Act.	30,000,000	24,800,000
Lead-Based Paint Poisoning Prevention Act of 1973.	25,000,000	6,500,000
Section 314(e) of the Public Health Service Act.	1/	13,100,000
Disease investigations, surveillance, and control		
Sections 301, 308, 311, 315, 322(c), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	Indefinite	40,049,000
Laboratory improvement		
Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	Indefinite	8,668,000
Health education		
Sections 301, 311, and 315 of the Public Health Service Act.	Indefinite	3,030,000
Occupational health		
Grants		
Sections 301 and 311 of the Public Health Service Act.	Indefinite	2,252,000
Direct operations		
Sections 301, 311, 327, and 328 of the Public Health Service Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	23,596,000
Program management		
Sections 301, 308, 311, 314(e), 315, 317, 318, 322(e), 325, 327, and 328 of the Public Health Service Act; the Lead-Based Paint Poisoning Prevention Act of 1973; the Federal Coal Mine Health and Safety Act of 1969: and the Occupational Safety and Health Act of 1970.	Indefinite	9,619,000
Total 1975		$137,814,000

1/ Section 314(e) of the Public Health Service Act expires June 30, 1974 - extension of legislation is proposed.

Preventive health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1965	29,995,000	29,974,000	29,974,000	29,974,000
1966	48,347,000	40,347,000	40,497,000	40,497,000
1967	44,230,000	44,220,000	44,220,000	44,220,000
1968	72,272,000	72,109,000	72,109,000	72,109,000
1969	63,407,000	62,144,000	62,144,000	62,144,000
1970	79,331,000	79,238,000	79,238,000	79,238,000
1971	82,138,000	82,538,000	90,600,000	84,538,000
1972	138,996,000	138,996,000	157,911,000	143,303,000
1973	139,980,000	159,872,000	223,872,000	159,872,000
1974	125,080,000	127,080,000	141,780,000	134,565,000
Supplemental	1,789,000			
1975	137,814,000			

Justification

Preventive Health Services

	1974 Base*		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	3,448	$56,235,000	3,508	$57,458,000	+60	+$1,223,000
Other expenses	---	79,958,000	---	81,320,000	---	+1,362,000
Total	3,448	136,193,000	3,508	138,778,000	+60	+2,585,000

General Statement

This appropriation provides support for the Center for Disease Control, one of the six agencies of the Public Health Service. This agency is the center of competence in the prevention and control of infectious diseases and certain other conditions. The agency's principal mission is to assist State and local health authorities and other health related organizations in stemming the spread of communicable diseases, in providing protection from some environmental hazards, and improving occupational safety and health. This mission is carried out in a multiphasic program which includes: (1) research, investigation, and evaluation of new methods of controlling or preventing diseases; (2) the provision of epidemic aid; (3) technical consultation and assistance in all aspects of communicable disease control; (4) active surveillance of disease and reporting on trends and developments; (5) laboratory improvement; (6) direction of a national health education program; and (7) occupational safety and health. In addition, this agency is charged with the responsibility for certain national health duties. These include the licensure of clinical laboratories engaged in interstate commerce and foreign quarantine activities aimed at preventing the introduction of disease into our Nation.

Hence, these programs are engaged in a wide spectrum of activities directed to improving the health of the people of this nation. The Center for Disease Control is an organization devoted to public service through assistance, research, investigation, and only when necessary, regulation and enforcement.

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*Excludes 1973 appropriation restorations.

Disease Control

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	2,657	$41,881,000	2,677	$43,099,000	+20	+$1,218,000
Other expenses	---	58,639,000	---	59,248,000	---	+609,000
Total	2,657	100,520,000	2,677	102,347,000	+20	+1,827,000
Subactivities:						
Project grants .... Sections 317 and 318 of the Public Health Service Act. Lead-Based Paint Poisoning Prevention Act. Section 314(e) of the Public Health Service Act.	667	50,600,000	667	50,600,000	---	---
Disease investigations, surveillance, & control .... Sections 301, 308, 311, 315, 322(c), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	1,495	39,657,000	1,505	40,049,000	+10	+392,000
Laboratory improvement ..... Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	459	8,527,000	469	8,668,000	+10	+141,000
Health education .. Sections 301, 311, and 315 of the Public Health Service Act.	36	1,736,000	36	3,030,000	---	+1,294,000
Total	2,657	100,520,000	2,677	102,347,000	+20	+1,827,000

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
PROJECT GRANTS						
Infectious diseases ...	657	$31,000,000	657	$31,000,000	---	---
Immunization	82	6,200,000	82	6,200,000	---	---
Venereal diseases ...	575	24,800,000	575	24,800,000	---	---
Rat control	---	13,100,000	---	13,100,000	---	---
Lead-based paint poisoning in children......	10	6,500,000	10	6,500,000	---	---

Immunization

Safe and effective vaccines which can prevent and control outbreaks of many communicable diseases are now available. Funds are being requested for immunization grants to assist States and local health agencies in planning, organizing, and conducting community-based ongoing immunization activities against poliomyelitis, measles, rubella, diphtheria, pertussis and tetanus.

During 1975, immunization project grants will be awarded to 62 State and local health agencies which serve all areas of the Nation. These grants will require recipients to develop and refine their capabilities; (1) to systematically immunize groups of inadequately immunized children; (2) to promptly detect and respond to local outbreaks of vaccine preventable and controllable diseases; (3) to conduct meaningful assessment and surveillance of immunity levels and disease trends; (4) to sustain adequate levels of immunity; and (5) to develop and conduct public and professional information, educational and motivational activities. Emphasis will be placed on determining those subgroups in the population with low immunity levels and designing and conducting immunization activities to take appropriate remedial action to close the gap between central city and non-central city immunity levels.

During 1974, immunization efforts were directed toward identifying and immunizing the large numbers of preschool-age children inadequately immunized against the vaccine preventable diseases (5.1 million for polio, 4.7 million for measles, 6.0 million for rubella, and 3.4 million for DPT). It is anticipated that the activities conducted in 1974 will be reflected by a proportional increase in immunization levels of 10 percent for measles, 11 percent for rubella, and 7 percent for polio in the 1-4 age group.

The 1973 funds restored in 1974 were used to fund increased project grants to States to enhance support of immunization programs against diseases susceptible to vaccination control, particularly replenishing supplies of vaccine.

Venereal Disease

With infectious syphilis at its highest reported level since 1950 and gonorrhea at the highest level ever reported, venereal diseases are epidemic in the United States. Since these are communicable diseases, they present a hazard to the Nation over and above that posed by illnesses which affect individuals and do not spread from one person to another. Factors combining to perpetuate the spread of these diseases include the extent of travel, the mildness or absence of early symptoms and the widespread ignorance that surrounds their transmission, diagnosis, and treatment. Because of the rapid spread of these diseases from area to area, control efforts must be applied nationally on a uniform basis.

Federal support for 1975 will expand and intensify the national venereal disease control effort. Project funds are principally directed to support the disease intervention activities of this effort. Screening, using presently available culture methods and other methodologies including serologic tests if they become available, will remain a major component of gonorrhea control strategy. Screening efforts in syphilis control will place emphasis on discontinuing nonproductive approaches and strengthening testing programs which merit it, such as in prenatal clinics, in hospital emergency rooms among certain high-risk patient groups, and in other appropriate settings.

Epidemiology is designed to achieve a rapid decrease in incidence through interruption of disease spread and will remain a major component of the overall control strategy. Major emphasis during 1975 will be placed on improving the quality of the epidemiology being performed in order to achieve the more rapid decrease in syphilis incidence, to broaden the gonorrhea screening net for infected females, to discover asymptomatic male as well as female gonorrhea cases, and to emphasize patient involvement in the epidemiologic process. A greater and more effective use of contact self-referral techniques will be made and approaches will be implemented to encourage the chronic repeater to return for frequent tests. A variety of follow-up procedures will be used to reduce the time interval between exposure and the time the contact receives diagnostic and treatment services.

During 1975, educational efforts will be directed towards communicating pertinent venereal disease facts to persons at risk, especially youth, with objectives of preventing exposure or re-exposure to infection and of having patients recognize the need for and to participate in the referral of their sexual contacts to medical care. A second strategy will address improving health care services, both through educational programs targeted to current providers, and stimulation of new programs for physician assistants.

Specific control techniques found to be effective will be transmitted to all State and local programs through regional offices and their use encouraged during onsite program evaluations conducted by CDC and the regional offices.

For the fourth straight year, reported cases of primary and secondary syphilis increased during 1973 as shown in the following table:

	No. Reported Cases FY'73	Increase Over FY'72	Estimated Actual No. Cases FY'73	Age of Greatest Risk
Primary & Secondary syphilis	25,080	4.5%	85,000 - 90,000	20-24 yrs.
Gonorrhea	809,681	12.7%	2,500,000	20-24 yrs.
Male	504,706	2.0%	1,700,000 -1,900,000	
Female	304,975	36.3%	600,000 - 800,000	

Provisional data for the first quarter of 1974 showed an encouraging decline in early syphilis incidence of 0.4 percent over last year's reports. Case detection and surveillance activities of the syphilis control effort tested an estimated 40 million persons for syphilis of whom 1,100,000 had reactive test results and of whom over 66,000 were identified with syphilis. Epidemiologic activities have resulted in the prevention of 2,700 cases of syphilis.

Gonorrhea continues to rank first among all reportable diseases. Reported cases of gonorrhea among females increased 36.3 percent in 1973 compared to 1972, but cases of gonorrhea among males rose only 2.0 percent. This is the lowest rate of increase among males in the past decade. This low rate of increase in males is attributable to the impact of the gonorrhea control program begun in 1973 which included the testing of five million women. Of these, 4.9 percent were positive for gonorrhea and 90 percent were treated.

Rat Control

The rat is a symptom of a deteriorated urban environment characterized by unsanitary conditions, dilapidated housing, and poor health and social conditions. Rats are responsible for spreading disease, destroying food and property, and causing fires and injuries.

Project grants are provided as seed money to demonstrate new methods of implementing program activities, and to carry out comprehensive programs focusing on permanent long-range solutions to control rat populations. The immediate objectives of the project grants for rat control are to reduce rat populations and the conditions which are conducive to rat infestations to a maintenance level (2 percent or less of the premises with active rat signs and either 15 percent or less of premises with exposed garbage or 30 percent or less of premises with unapproved refuse storage).

Emphasis in 1975 will be placed on accelerating the attainment of a maintenance level in existing target areas by focusing more strongly on the elements of community involvement and local administration which are vital to the long-term solution of the problem. The initial group of projects has demonstrated that the residents of target neighborhoods can be mobilized to take the steps necessary to reduce rat populations, and that the community as a whole can assume responsibilities for maintaining surveillance and maintenance programs with declining federal support. In addition, grant funds will increasingly be used to initiate control programs in new target areas of existing project communities where where rat infestations have developed. By 1975, new rat control projects can be initiated with shorter time frames for achieving a state of control. Surveillance methods, and the methods of mobilizing all relevant municipal services to deal with persisting or potential infestations, will be more clearly developed.

A maintenance level of control was reached in 47 percent of the target areas by the end of 1973. It is estimated that this percentage will be increased to 50 percent by the end of 1974, and to 50 percent by the end of 1975. Local funds are currently providing an average of 45 percent of the total funds supporting rat control projects.

Lead-Based Paint Poisoning in Children

The potential for lead poisoning exists wherever lead-based paint is accessible to children, especially in deteriorating housing where peeling paint chips are found. There are an estimated 2.5 million children in the United States between the ages of one and six who are living in dilapidated housing with interior surfaces containing lead paint.

Since late in 1972, project grants have been awarded to communities to screen children for undue lead absorption as disclosed by elevated blood lead levels. Continuing in 1975, screening will be expanded to additional target groups. It is anticipated that a minimum of 300,000 individual children will be tested.

Emphasis will also be placed on developing the necessary laboratory competence in blood lead analysis in States and communities which have not yet put this emerging technology to work, and in strengthening it in areas where laboratory proficiency has been weak during the initial year of the program. New screening and laboratory procedures, as they are developed and evaluated, will be incorporated into existing programs.

During 1973, over 275,000 children were screened in 40 project communities. Approximately 10 percent were found on initial testing to have blood lead levels exceeding 40 micrograms per 100 milliliters of whole blood--the generally accepted level suggesting potential undue lead absorption. Of these, approximately 4,600 required treatment. Approximately 25,000 dwelling units were inspected as a result of these screening results, and hazard reduction actions were documented in 9,300 of these.

The 1973 funds restored in 1974 are being used to strengthen capabilities of State health laboratories to perform sophisticated and accurate blood lead analysis.

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease Investigations, Surveillance, & Control	1,495	$39,657,000	1,505	$40,049,000	+10	+$392,000

Investigations

The Center for Disease Control conducts epidemiological and clinical investigations of selected diseases of public health significance.

For example, during 1975 surveillance and investigations of hospital-acquired infections will continue. Efforts will be made to further improve the quality of surveillance data from hospitals. Laboratory efforts will be directed toward rapid identification of the causative agent and the institution of prompt control or corrective measures.

The Center will carry out research and investigations on viral hepatitis. Improved service to the States in the diagnosis of hepatitis B will be provided. Studies on detection and quantitation of hepatitis antigen-antibody complexes in relation to possible autoimmune reactions will be performed. In 1975, greater emphasis will be placed on determining populations at highest risk. Nationwide surveillance will be improved with particular stress on encouraging State health departments to report all hepatitis cases in detail.

Arboviral diseases are those which are transmitted to man and animals by the bites of arthropods, such as mosquitoes and ticks. Past studies have identified the principal arthropods that transmit these viruses to man and have revealed which types of wild birds and mammals are involved in the cycles that maintain the viruses in nature during non-epidemic periods. Insecticidal methods for mosquito control have been developed in recent years and will be further refined. Research is being carried on to find a longer-lived, highly competitive strain of mosquitoes for use in a sterile male release program. CDC will also assess the importance of and elucidate the vector/host/parasite relationships of such tropical diseases as encephalitis, onchocerciasis, malaria, filariasis schistosomiasis, dengue, and trypanosomiasis.

During 1974, epidemiological support was provided during outbreaks of streptococcal infections. This support not only provided the basic information needed to control these outbreaks, but yielded data that led to better understanding of the epidemiology and prevention of additional epidemics. Beginning in 1975, standardized reagents and procedures will be developed which can be used by all laboratories with increased reproducibility and interpretation in terms of diagnosis and monitoring of the effect of therapy.

In recent years, there has been a progressive increase in secondary fungus infections in patients with malignancies and other chronic diseases, in organ transplant recipients, and in patients receiving broad-spectrum antibiotics and steroids. To assist the many hospitals and health departments that lack medical mycological competency, the CDC provides a national diagnostic service. Annually, more than 17,000 specimens are processed requiring over 100,000 tests.

Surveillance

Current accurate disease intelligence is fundamental to the development and execution of effective control programs. Disease surveillance activities of the Center for Disease Control cover diseases of public health significance occurring in this country or presenting a threat of introduction into this country.

The Center will improve surveillance of disease trends at all levels--local, State, and federal. The principal mechanism for this is the Epidemic Intelligence Service. EIS Officers provide a ready supply of epidemiologists to work on epidemic investigations throughout the country and overseas on a moment's notice. At times they are the sole source for States to call upon for investigations. The full resources of the Center are made available for all field investigations.

Besides the use of traditional methods of influenza surveillance such as excess mortality data reporting, reporting from hospitals, and utilizing absentee data from large communities, efforts will be made to utilize and augment other existing health surveys in cooperation with the National Center for Health Statistics. By cooperative expansion of their data base and by improving their techniques of data gathering, it is hoped that more specific and sensitive information regarding the occurrence of influenza on a regular basis each year can be made. Comparisons of various surveillance systems will then be possible to determine the most specific and sensitive system to be used nationwide. Because of the real possibility that birds and other animals may serve as a source of influenza virus for humans, a systematic collection of bird sera for serology and isolation is planned.

The Center will continue to dispense drugs from the Parasitic Disease Drug Service, and provide consultative services to practicing physicians and health departments. Greater emphasis will be placed on clinical immunology. This program will be expanded and a study on immunoglobulin and complement levels in patients with suspected immunological deficiencies will be made. A number of laboratory assays will be established for cell-mediated immune competence in patients with suspected immunologic defects, and a program will be initiated for the preparation and standardization of tumor-specific antigens for use in diagnostic assays of patients.

Services in support of investigation and control of plague and related zoonoses will be available on request. Field and laboratory research will be directed toward obtaining critical data on the ecology and epidemiology of plague, tularemia, and related zoonoses. The data obtained will be used to develop and improve prevention and control measures.

CDC will continue surveillance and investigations of bacterial zoonotic diseases. Specific emphasis will be placed on the continuation and completion of studies of abattoir-associated brucellosis, the field evaluation of the indirect hemagglutination test for leptospirosis, and evaluations of a newer, more effective, outer-envelope vaccine for leptospirosis.

CDC will evaluate present procedures and subsequently design, develop, and implement efficient and effective alternate procedures for carrying out our responsibilities under the International Health Regulations. The Center will evaluate the feasibility of, and if applicable implement, modified inspection procedures at airports comparable to the maritime inspection procedures - that is, selective inspection based on risk. Efforts will continue to be directed toward providing easily accessible and accurate information on immunization requirements and recommendations to United States citizens traveling abroad. One primary objective in 1975 will be to assist the World Health Organization in completing the global smallpox eradication ahead of schedule. We will continually reevaluate the risk of importation of smallpox into the U. S. in light of progress on this global eradication program.

Control

The Center for Disease Control provides national leadership and technical direction in developing and implementing programs directed at prevention and control of a number of diseases of major public health significance. The programs are directed toward realistic priorities and objectives determined by use of modern demographic techniques and disease intelligence. The Center, in conjunction with the Regional Offices, will provide national direction, leadership, consultation, and technical assistance to State, local, and other Federal health agencies; conduct disease and vaccine surveillance; review, analyze and evaluate local immunization programs; assure the assessment of immune status and the appropriate use of vaccines; coordinate a nationwide educational and motivational effort to identify and insure the immunization of large numbers of unprotected preschool age children; conduct investigations and studies on vaccines and their application; and provide epidemiological assistance to control outbreaks of immunizable diseases. Close and effective collaborative working relationships with appropriate Federal agencies will be developed and maintained to insure the inclusion of immunization practice standards in guidelines and regulations related to vaccine preventable disease practices managed by these offices.

Excellent methods exist to control TB in the United States. Emphasis in 1975 will be to make these methods more efficient and to insure through technical assistance the implementation of these methods in the health care delivery system of the Nation. Emphasis will be placed on improving casefinding and case prevention in those population groups likely to be infected with or exposed to tuberculosis. Research efforts will be directed towards developing new methods and evaluating existing methods for the control of tuberculosis.

In the control of venereal diseases the major objectives for 1975 will be the further development and implementation of the nationwide program. National leadership and technical assistance will be provided, in conjunction with the Regional Offices, to increase the effectiveness of venereal disease control programs by refining casefinding and prevention techniques and screening methodologies for identifying infectious cases, and intensifying educational activities designed to motivate people to avoid risk of exposure and to seek examination when they believe exposure has occurred. Syphilis research will focus on cultivating Treponema pallidum in vitro. Studies will be conducted in the growth of T. pallidum in a hemodialysis system using various animal models and in the development of a defined medium for the in vitro growth of T. pallidum. Expanded research efforts will be directed to laboratory diagnostic techniques, immunology and drug susceptibility of the gonococcus.

During 1975, the Center's technical assistance capability will be strengthened in rodent control, prevention of lead-based paint poisoning, and related areas of environmental health. Technical consultation in rat control will focus on accelerated methods of achieving a maintenance level, and on methods of rat surveillance and response to potential infestations. In lead-based paint poisoning prevention, priority will be placed on improving laboratory competence in blood lead analysis. Special attention will be given to the development of statewide laboratory competence in support of expanded screening programs envisioned through the Early and Periodic Screening, Diagnosis, and Treatment Program under Medicaid.

The net increase of $392,000 and 10 positions includes an increase of $1,229,000 for built-in increases, such as annualization of pay raises in 1974 and extra day of pay; a program increase of $130,000 and 10 positions to support expanded research and development leading to further refinement and implementation of surveillance methods and analytic techniques in the National Nosocomial Infections Study, surveillance of community-acquired infections, and evaluation of control measures; and a program decrease of $967,000 resulting from nonrecurring purchases of equipment and closing of the Arctic Health Research Center.

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Laboratory Improvement....	459	$8,527,000	469	$8,668,000	+10	+$141,000

The Center for Disease Control administers a comprehensive national laboratory improvement program by conducting research and development programs for the evaluation, standardization, and effective application of laboratory methodology. It operates a national reference laboratory service in the disciplines of bacteriology, mycology, virology, parasitology, clinical chemistry, hematology, and pathology, and provides assistance to laboratories of States, large municipalities, and, under the auspices of the World Health Organization, foreign countries. This assistance is in the form of consultation, laboratory management service, and dissemination of new and/or improved procedures. In cooperation with the Food and Drug Administration, CDC develops performance standards for commercial products used in clinical laboratories for the diagnosis of human diseases. Under authority of the Clinical Laboratories Improvement Act (CLIA) of 1967, CDC is responsible for licensing and proficiency testing of laboratories engaged in interstate commerce. Other major functions include providing extensive remedial short-term instruction programs in the field of laboratory practice, producing and distributing microbiological reference reagents for standardization and quality control purposes, evaluating commercial reagents, and distributing experimental vaccines and special immune globulins.

A combination of circumstances has created a unique opportunity for the CDC to play a leading role in the improvement of national health laboratory services. Since 1966, laboratory quality standards for Medicare and CLIA, and more recently the regulations issued by the FDA for controlling in vitro diagnostic products, have made possible the development and consensus acceptance of standards of performance previously difficult or impossible to achieve. Laboratory improvement can be accomplished only when acceptable basic laboratory technology is developed in three areas: analytical methods, quality calibration and control materials, and means of quality assessment and control. Research and development in any one of these areas requires parallel development in the other two. If the goals of the laboratory improvement programs are to be attained in each of the more than 12,000 health laboratories of the Nation, the basic technologies must be efficiently and effectively learned and practiced in each laboratory.

During 1975, the CLIA standards will be applied to an estimated 1,150 laboratories, an increase of 125 over 1974. Under an agreement between the CDC, HSA, and the SSA, the CDC will continue to develop identical technical laboratory standards, in both language and intent, resulting in more than half of the Nation's estimated 12,000 clinical laboratories being brought under a single set of standards. An additional significant increase is projected for the number of nonprofit clinical laboratories which will request participation on a voluntary basis in the proficiency testing part of the CLIA program. At the midpoint of 1974, there were 1,338 volunteer laboratories participating in proficiency testing; by the end of 1975, it is estimated that the number will be 1,520.

Several Federal programs have requested assistance in evaluating clinical laboratories for which they are responsible. During 1975, CDC expects to provide one or more parts of its evaluation program to 40 clinical laboratories which serve the Department of Labor Job Corps Centers, 73 laboratories which serve Indian hospitals and clinics, and 600 laboratories involved in the national gonorrhea screening program. In addition, twelve new types of samples will be prepared for the disciplines of cytopathology, diagnostic immunology, hematology, chemistry and bacteriology.

The CLIA continues to provide an excellent base for defining deficiencies in the Nation's clinical laboratories, and a substantial measure of improvement has been achieved by calling to the attention of laboratory directors those problems which are readily correctable. Implementation of the Act has also demonstrated an urgent need for remedial short-term instruction of laboratory personnel to prevent their skills from becoming obsolete as pertinent scientific information continues to increase at a phenomenal rate. The need for extremely specialized blocks of applied information poses a major problem for conventional educational institutions since the structure of formal academic courses does not lend itself to the presentation of such specialized information. While a small staff at the federal level cannot and should not provide instruction to the 150,000 to 200,000 laboratory personnel requiring it, it is possible to create a "multiplier effect" by providing missing critical elements to agencies now engaged in continuing education. This is done by (1) directing laboratory instruction toward updating the knowledge of supervisors not only in the latest laboratory developments, but also in the skills required to teach them on a regular basis at the local level; (2) developing functional teaching aids; and (3) providing resource personnel to State and local programs.

During 1975, activities will focus on providing technical assistance to State health departments in the conduct of their own training courses. In headquarters courses, the emphasis will be on instruction in new laboratory methodology that has resulted from research efforts and on presenting information to meet special national needs, such as how to diagnose cholera and hepatitis.

Standards for commercial diagnostic products continue to be of primary importance in laboratory improvement activities. The CDC strengthened its cooperative efforts with FDA in establishing and validating essential reference methodologies and in developing product class standards. In the area of clinical chemistry, standards for calibration materials and for products used in glucose analysis were developed. At the request of the Government Accounting Office, 44 separate commercial packaged reagents and "kits" for clinical chemical analyses were evaluated. Although the quality of these commercial products varied among the different analytical fields, most of them did not meet our postulated standards of acceptability. In collaboration with the National Bureau of Standards, the CDC prepared standard reference materials for national distribution and checked them against definitive methods. These serum reference materials with assigned values for six electrolytes represent the first such standard materials in the clinical chemistry field. In hematology, product class standards have been completed for normal and abnormal hemoglobin determinations. Standards for products used to determine prothrombin time are now being developed. The need for continuing development of standards for chemistry and hematology products is evident since determinations of this type are among the most commonly requested laboratory diagnostic tests.

Work is also progressing in the area of microbiological and immunological _in vitro_ diagnostic products. Activities include (1) preparation of performance and labeling specifications for microbiological and immunological products, (product class standards have been completed for FDA for products used in the diagnosis of rubella, rabies, and syphilis, and for media used in the cultivation of _Neisseria gonorrhoeae_); (2) preparation and distribution of reference or standard reagents; and (3) evaluation of commercial products before they are marketed, as well as limited monitoring of marketed products.

Of 474 commercial premarket serologic reagents evaluated for a 5-month period (July 1 to November 30, 1973), 79.5 percent of the venereal disease (VD) reagents and 77.7 percent of the non-VD reagents met the CDC product specifications of standards. Of the 405 lots of commercial media for the transport or growth of _Neisseria gonorrhoeae_, only 76.3 percent were satisfactory.

The 4th edition of "CDC Specifications for Microbiological Reagents" covering 2,000 microbiological products will be printed in 1975, providing a major thrust to be made by the CDC and the FDA in developing standards for in vitro diagnostic products. These specifications can be included under FDA regulations according to priorities established by that agency. When new standards are developed, concentration will be centered on critical diagnostic materials in the disciplines of clinical chemistry, hematology, and toxicology. The CDC will continue to expand its voluntary premarket evaluation of commercial diagnostic materials in order to monitor the quality of such products until they are subject to formal product class standards in FDA regulations.

Over 125,000 reference diagnostic specimens were processed during 1974. These were received primarily from State health departments and they represent the most difficult diagnostic problems encountered. The number of reference diagnostic tests performed continued to increase and for 1975 is expected to reach 130,000. The increase was a result of newly developed procedures and of efforts to provide new services, such as determining the etiology (rubella, cytomegaloviruses, herpesvirus, and toxoplasmosis) of certain birth defects.

Major research investigations during 1974 were directed toward: (1) more sensitive methods for the detection of drugs of abuse in urine, blood, and tissue; (2) determination of the optimal conditions and ingredients in standard media for the cultivation of gonococci in order to improve the quality of such commercially prepared media; (3) development of serologic procedures for the diagnosis of parasitic infections; (4) definition of the ecology of Lassa fever; (5) development of laboratory procedures for typing variants of Australia antigen (hepatitis); and (6) improvement of reagents for the prompt identification of new influenza viruses. Research will continue to be directed toward laboratory diagnostic methodology which is rapid, reliable, sensitive, specific, and based on sound immunological principles.

During 1974, 1,025 clinical laboratories were evaluated by CDC or by the CDC-approved College of American Pathologists program and State programs. The laboratories were evaluated on the qualifications of personnel, the adequacy of their internal quality control programs, and the adequacy of their performance with proficiency testing specimens, in accordance with the standards of good laboratory practice promulgated under the CLIA. Of these 1,025 laboratories, 900 qualified to accept interstate specimens. In addition, 1,435 nonprofit clinical laboratories participated voluntarily in the proficiency testing program.

Analysis of results of proficiency testing demonstrated statistically significant improvement in microbiology and clinical chemistry for those licensed laboratories which had participated in the total evaluation program for two or more years. Comparable volunteer laboratories did not show significant improvement over the same time. In spite of significant general improvement, 20 to 40 percent of the participating laboratories performed poorly in several categories of microbiology, with grades of less than 75. In the categories of clinical chemistry, 10 to 20 percent performed poorly. This clearly indicates the need for continued sharply focused remedial efforts to follow-up the evaluation process.

The 1973 funds restored in 1974 are being used for a national conference on quality control in public health laboratories and for purchase of bulk laboratory material for proficiency testing.

The net increase of $141,000 and 10 positions includes an increase of $141,000 for annualization of pay raises in 1974 and an increase of $120,000 and 10 positions to allow the Center to extend the application of the high standards of the CLIA to more of the Nation's clinical laboratories at a faster rate. By more rapid implementation of existing cooperative agreements with other Federal agencies, primarily the Social Security Administration, the CLIA standards, including on-site evaluation and proficiency testing, can be extended to approximately 6,000 laboratories in the SSA-Medicare program. This compares with the approximately 1,400 laboratories now covered by the CLIA regulations. It is extremely urgent that these standards be applied as soon as possible to all clinical laboratories. This program increase of $120,000 is offset by a corresponding built-in program decrease of $120,000 for nonrecurring equipment acquired in 1974.

	1974 Base Pos.	1974 Base Amount	1975 Pos.	1975 Amount	Increase or Decrease Pos.	Increase or Decrease Amount
Health Education	36	$1,736,000	36	$3,030,000	---	+$1,294,000

The Center for Disease Control will, in 1975, provide leadership and direction of a national health education program aimed at preventing disease, disability, premature death, and undesirable and unnecessary health events. The funds requested are for the operating support of the Center's efforts to enhance the total effectiveness of the wide range of separate federal programs having purposes related to health education. An important component of the program will be an effort to use more effectively, for health education purposes, the HEW Regional network.

Major ongoing health education efforts in federal and other publicly supported programs will be identified. Coordination with health education activities of other PHS, DHEW, and outside agencies will be accomplished through the establishment of an active Intradepartmental Committee, chaired by the Assistant Secretary for Health and staffed by the Center for Disease Control. Collaborative efforts among high priority health programs to accomplish health education objectives, including cooperation with other federal and outside agencies will be developed. Services to such programs will be provided, e.g., advice on proposed initiatives, a mechanism for testing specific health education hypotheses, putting people in touch with others doing similar activities, and attempting to reduce duplications.

Priorities for health education activities will be developed and recommended. Criteria for health education projects and proposals, taking into account priority health problems, target populations, and effective pathways for communications such as mass media, school curricula, and community outreach programs will be developed and promulgated.

High risk population groups for multiple diseases will be identified and education programs aimed at the group rather than the diseases will be developed, e.g., the high risk population group for lung cancer, hypertension, cervical carcinoma, and venereal disease in black women. Therefore, experimental programs of delivering basic health education, as against health information, will be developed for this population group.

Information will be disseminated about especially effective techniques, strategies, approaches, and about methods that have proved ineffective. Techniques of conveying health education in a variety of delivery systems will be demonstrated, e.g., the effectiveness of specialized education conducted in Health Maintenance Organizations.

The feasibility of forming a health education consortium outside the government (private) will be explored and recommendations will be made on its potential interests, activities, and resources to establish a non-governmental National Center for Health Education. A developmental contract will be awarded to aid in delineating the appropriate role of this Center.

The Center for Disease Control will: continuously monitor selected ongoing programs; assess their relative effectiveness; establish pilot-demonstration health education programs; encourage and assist broader application of demonstratedly effective health education programs at the community level; develop standards, criteria, methodology for improved evaluation of health education programs; and develop a plan for systematic behavioral research pertinent to federal health education priorities.

The Center will also serve as a clearinghouse/information center for response to or referral of health education inquiries and will conduct continuing liaison with private sector health education activities.

Emphasis will be placed on the control aspects of the smoking and health problem. Evaluation of prevention and control activities will be of major interest, as well as smoking related behavioral research. Consultation will be provided to national and local organizations engaged in anti-smoking activities to control and resist the harmful effects of cigarettes. The priority efforts of this program will be targeted toward having youths make the personal decision not to take up cigarette smoking, increasing the rate at which women stop smoking, helping adults who want to quit, and having those who continue to smoke do so with less hazard.

The Center will act as the coordinator for Department activities relating to smoking and health and will maintain liaison with other federal agencies and with official and voluntary groups concerned with the problem. Consultation will be provided to State and local interagency councils and to industrial and local groups in developing coordinated community approaches to smoking control programs. In addition, the annual report reviewing the medical and scientific evidence on the health consequences of smoking will be submitted to Congress.

The FY 1973 funds restored in 1974 will be used for chronic disease and nutrition activities.

The increase of $1,294,000 includes $44,000 for a built-in increase for annualization of pay raises in 1974 and $1,250,000 for the first full year of operation of the national health education program.

Occupational Health

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	525	$8,916,000	565	$9,217,000	+40	+$301,000
Other expenses	---	20,213,000	---	16,631,000	---	-3,582,000
Total	525	29,129,000	565	25,848,000	+40	-3,281,000

Grants

	1974 Base		1975		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
1. Non-competing continuations ...	41	$1,798,000	55	$2,027,000	+14	+$229,000
2. New grants	12	454,000	6	225,000	-6	-229,000
Total	53	2,252,000	61	2,252,000	+8	---

Research grants are used to complement the research effort of the National Institute for Occupational Safety and Health. They provide research competencies from qualified institutions in certain fields not available within the Institute. In 1975, it is expected that 61 research grants in the amount of $2,252,000 will be awarded.

In 1974, 44 research grants will be awarded. In addition, 9 training grants will be let for the development of a viable training curricula to support the growing enrollment of students seeking professional and technical training in occupational safety and health.

The 1973 funds restored in 1974 in the amount of $1,512,000 will fund research and training grants for the development of analytical procedures for detection of carcinogens and to supplement criteria for standards development.

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Direct Operations	525	$26,877,000	565	$23,596,000	+40	-$3,281,000

The National Institute for Occupational Safety and Health conducts research, develops criteria for occupational safety and health standards, and provides technical services to government, labor and industry. These functions are designed to reduce the high economic and social costs of occupational illness and injury through the prevention and control of occupational diseases and hazards. They are authorized under the Public Health Service Act as amended, Federal Coal Mine Health and Safety Act of 1969, and Occupational Safety and Health Act of 1970, and are supported by direct operation funds.

Some of the Institute's specific objectives for 1975 include:

1. Completing criteria for the following 14 hazardous substances or harmful physical agents: hexavalent chromium compounds, ammonia, chloroform, nitrogen dioxide, sodium hydroxide, fluorides, methylene, chloride, nitric acid, xylene, aniline, dioxane, zinc oxide, and fibrous glass; also, completing a work practice document for egress from high structures;
2. Publishing the fifth annual list of Toxic Substances;
3. Conducting industrywide epidemiologic studies of the effects of chronic or low level exposure to industrial materials, processes, and stresses on the potential for illness, disease, or loss of functional capacity in past and present workers in 10 industries;
4. Continuing the second round of medical examinations of the 90,000 underground coal miners in order to assure detection of physical impairment due to unhealthful working environments in accordance with the Federal Coal Mine Health and Safety Act;
5. Providing for an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung Benefits;
6. Stimulating occupational health and safety programs in State and local governments and in industry, and providing technical assistance and information through field stations and regional offices.

During 1974, the Institute will:

1. Transmit to Department of Interior, for promulgation, regulations for health standards governing asbestos, noise, and carbon monoxide in surface coal mines;
2. Test and certify more than 200 protective devices and samplers for use by coal miners;
3. Complete development of criteria for occupational safety and health standards covering carbon tetrachloride, arsenic, cadmium, sulfur dioxide, sulfuric acid, silica, parathion, benzene, nitric oxide, zinc chloride, cotton dust and fibrous glass;
4. Issue regulations governing the conduct of industrywide studies and the testing and certification of personal protective devices;

5. Complete the National Occupational Hazard Survey, a two-year effort to develop basic descriptive information on the working environment of all nonagricultural industries covered by the Occupational Safety and Health Act;

6. Provide on-site technical assistance to more than 175 establishments;

7. Respond to more than 200 requests from employers or authorized representatives of employees for determination of whether substances normally found in place of employment have potentially toxic effects;

8. Develop and demonstrate prototype in-plant occupational safety and health programs;

9. Provide 1,300 man-weeks of training on a fee-for-service basis in the avoidance or elimination of unsafe and unhealthful working conditions.

The 1973 funds restored in 1974 were used to fund research contracts for the development of analytical procedures for detection of carcinogens and to supplement criteria for standards development.

The decrease of $3,281,000 includes a built-in increase of $301,000 for annualization of pay raises in 1974, and a program decrease of $3,582,000 resulting from nonrecurring program efforts in 1974 to expand the capacity of clinical occupational respiratory disease services available to coal miners. These clinics are expected to become self-sufficient in 1975 through third-party reimbursements and will require no further federal support.

Buildings and Facilities

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses	---	---	---	$964,000	---	+$964,000

(Title III of the Public Health Service Act)

Funds for this activity remain available until expended. Unobligated amounts were transferred from the Health Services and Mental Health Administration's Building and Facilities appropriation to this appropriation. No new budget authority is requested.

In 1975, funds will be obligated for the repair and improvement of existing facilities necessary to maintain acceptable standards. Miscellaneous projects will include fire and safety improvements, alterations and additions to mechanical systems, and replacement of roofs and floors.

The increase of $964,000 results from the transfer of the HSMHA Buildings and Facilities appropriation.

Program Management

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	266	$5,438,000	266	$5,142,000	---	-$296,000
Other expenses	---	1,106,000	---	4,477,000	---	+3,371,000
Total	266	6,544,000	266	9,619,000	---	+3,075,000
Subactivities:						
Program direction .. (Sections 301, 308, 311, 314(e), 315, 317, 318, 322(e), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act; the Lead-based Paint Poisoning Prevention Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.)	174	4,161,000	174	7,319,000	---	+3,158,000
Regional offices ... Sections 311, 314(e), 317, and 318 of the Public Health Service Act; the Lead-based Paint Poisoning Prevention Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.)	92	2,383,000	92	2,300,000	---	-83,000
Total	266	6,544,000	266	9,619,000	---	+3,075,000

Program Direction

The Center for Disease Control, through the direct utilization of these funds, will provide the executive direction and resource management staff necessary for planning, directing and evaluating all program activities in 1975. The activities of the Center, being both national and international in scope, makes it imperative that high quality staff support be maintained. These funds will enable the Center to fulfill its responsibility for proper stewardship of resources and to provide assistance and coordination to the Assistant Secretary for Health. The cost of renting building space formerly budgeted by GSA will be funded from this activity in 1975.

Regional Offices

In 1975, the Center for Disease Control will continue to provide direct fund support and competent staffing to the ten Regional Offices. These offices will provide consultation, assistance, and services to State and local health agencies with respect to grant supported programs for disease control, rodent control, and prevention of lead poisoning in children, and serve as the focal point for the review of State plans and grants for the control of occupational diseases and work injuries. The staff of the Regional Offices will also provide technical supervision to field personnel working in nationwide surveillance programs on venereal disease and diseases which can be controlled through immunization.

The net increase of $3,075,000 includes $3,472,000 for built-in increases such as annualization of pay raises in 1974 and payment of rental charges, and program decreases of $397,000 due to annualization of savings from position reduction and to completion in 1974 of the two-year National Occupational Hazard Survey to develop basic descriptive information on the working environment of nonagricultural industries covered under the Occupational Safety and Health Act.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Disease Control (Title III of the Public Health Service Act).

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
2,657	$100,520,000	Indefinite	2,677	$102,347,000

Purpose: Preventing illness and maintaining scientific surveillance of diseases.

Explanation: The purpose is accomplished through project grants and a multiphasic direct operation program of investigations, research, and technical assistance, concerned with detection and prevention of communicable and other preventable diseases or conditions. These activities are focused directly on the national goal of improvement of health care systems through emphasis on prevention rather than treatment.

Accomplishments in 1974: Mass gonorrhea screening of female populations resulted in five million women receiving bacteriologic culture during 1974. Of these, 4.9 percent were positive and 90 percent of those found to be infected were treated. As a result, women with asymptomatic gonorrhea, previously undetected for long periods of time, are being identified and cured.

Case detection and surveillance activities of the syphilis control effort tested an estimated 40 million persons for syphilis of whom 1,100,000 had reactive test results and of whom over 66,000 were identified with syphilis. Epidemiologic activities have resulted in prevention of 2,700 cases of syphilis.

During 1974, immunization efforts were directed toward identifying and immunizing the large numbers of preschool-age children inadequately immunized against the vaccine-preventable diseases (5.1 million for polio, 4.7 million for measles, 6.0 million for rubella, and 3.4 million for DPT).

A maintenance level of rat control was reached in 47 percent of the target areas by the end of 1973. It is estimated that this percentage will be increased to 50 percent by the end of 1974.

Since late in 1972, project grants have been awarded to communities to screen children for undue lead absorption as disclosed by elevated blood lead levels.

During 1974, the CDC provided national leadership and direction in the coordination, management, and conduct of community immunization programs. Leadership was provided in the coordination and conduct of a nationwide, cooperative, education-motivational effort to reverse the trend of immunization levels among preschool-age children against measles, rubella, polio, diphtheria, pertussis, and tetanus.

The shift from long-term sanatorium care for tuberculosis to general hospitals and ambulatory care was promoted by the Center, and present statistics reveal 8,000 beds used for TB in specialized TB units in 1973 compared with 10,700 in 1972.

In 1974, the Center for Disease Control handled approximately 1,200 epidemic aid requests. The Center currently publishes 28 separate surveillance reports that summarize data collected from throughout the Nation. The Morbidity and Mortality Weekly Report, published weekly by the Center, has a circulation of approximately 30,000 and is the principal mechanism of providing surveillance and epidemiologic data to the overall national health establishment. During the past year, the Parasitic Disease Drug Service, in conjunction with the foreign quarantine activities, provided drugs for more than 2,000 patients with parasitic diseases; such as, Pneumocystis carinii pneumonia, African sleeping sickness, malaria, etc., many of which are life threatening. Over 125,000 laboratory reference diagnostic specimens were processed.

During 1974, 1,025 clinical laboratories were evaluated by CDC or by the CDC-approved College of American Pathologists program and State programs. Of these 1,025 laboratories, 900 qualified to accept interstate specimens. In addition, 1,435 nonprofit clinical laboratories participated voluntarily in the proficiency testing program.

More than 200 lots of laboratory reference and control materials were produced and distributed, and approximately 300 vials of zoster immune globulin were produced to treat life threatening cases of chickenpox in immunologically deficient children. Over 2,200 lots of commercially prepared diagnostic products were evaluated prior to marketing.

Objectives for 1975: In 1975 major emphasis will be placed on improving the quality of the epidemiology being performed in order to achieve the more rapid decrease in syphilis incidence, to broaden the gonorrhea screening net for infected females, to discover asymtomatic male as well as female gonorrhea cases, and to emphasize patient involvement in the epidemiologic process.

In 1975 program efforts will be directed toward attacking rat problems in key urban areas where these rodents persist. It is estimated that a maintenance level of control will be reached in 50 percent of the target areas by the end of 1975.

Screening surveillance of an increasing portion of the some 2.5 million children now estimated to be at risk for lead-based paint poisoning will be carried out. An improved surveillance and program evaluation system will be implemented, based on the experience of project areas during the first years of the program and it is anticipated that approximately 300,000 children will be tested by the end of 1975.

The objective of TB control in 1975 is to make control methods more efficient and to insure the implementation of these methods in the health care delivery system of the Nation. Disease surveillance and epidemiologic capability at the State, national and international level will be strengthened to improve the control of disease and to prevent the importation of diseases, such as smallpox and cholera, into the U. S. from other countries.

Under the Clinical Laboratory Improvement Act, the CDC will apply common standards to all CLIA and Medicare independent laboratories, thus bringing a large segment of the Nation's clinical laboratories under a single set of standards. Laboratory training activities will focus on providing technical assistance to State health departments in conducting their own training courses. A major thrust will be made in the development of standards for in vitro diagnostic products to be regulated by the Food and Drug Administration.

The Center will continue to provide leadership and direction for a national program to reduce death and disability due to smoking. The priority efforts of this program will be targeted toward having youths make the personal decision not to take up cigarette smoking, having women who smoke increase their rate of cessation, helping adults who want to quit, and having those who continue to smoke do so with less hazard.

In providing leadership and direction of a national health education program, the Center will develop and promulgate health education goals, objectives, and priorities. The Center will seek to avoid unnecessary duplication and undesirable competition among various federal categorical health education efforts, and insure, wherever appropriate, that such programs work together. Standards or criteria for more effective evaluation of health education activity will be developed. Effort will be made to use more effectively for health education purposes the HEW regional network. The Center will serve as the focal point or point of entry for federal collaboration with the private sector in health education.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Occupational Health (PHS Act as amended, Federal Coal Mine Health and Safety Act of 1969, and Occupational Safety and Health Act of 1970)

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
525	$29,129,000	Indefinite	565	$25,848,000

Purpose: This program is designed to reduce the costs of occupational illness and injury through the prevention and control of occupational hazards and diseases.

Explanation: Grants and direct operation funds are used to support research and technical assistance programs aimed at helping government and industry to administer occupational health programs, and to develop criteria for standards.

Accomplishments in 1974: In 1974, regulations will be promulgated under the Federal Coal Mine Health and Safety Act for health standards for surface coal mines. Also, it is anticipated that 240 protective and monitoring devices will be tested.

Under the Occupational Safety and Health Act (P.L. 91-596), twelve documents will be sent to the Department of Labor in 1974. The annual List of Toxic Substances will contain 20,000 hazardous substances.

In 1974, regulations governing the conduct of industrywide studies and for testing and certification of personal protective devices will be published in the Federal Register. The National Occupational Hazard Survey will be completed. On-site technical assistance will be provided to more than 175 establishments in 1974. Prototype in-plant occupational safety and health programs will be demonstrated in 1974. In 1974, 1,300 man-weeks of direct training will be provided on a fee-for-service basis.

Objectives for 1975: The four specific program priorities to be emphasized in 1975 are: (1) to make recommendations for 14 occupational health and safety standards, and publishing a "List of Toxic Substances"; (2) to conduct research and industrywide studies; (3) to develop health standards, to complete a preventive examination program for 90,000 underground miners and to provide an estimated 500 autopsies of deceased coal miners; (4) to stimulate occupational health and safety programs and to provide technical assistance and information.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Building and Facilities (Title III of the Public Health Service Act)

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	---		---	$964,000

Purpose: For construction, alterations, and repairs and improvements of buildings and facilities, including preparation of plans and specifications.

Explanation: No new budget authority is requested for 1975. Prior year available funds were transferred from the HSMHA Buildings and Facilities appropriation to this appropriation.

Objectives for 1975: Repair and improvement of existing facilities will be accomplished as required to maintain acceptable standards.

Center for Disease Control

Preventive Health Services

Program Purpose and Accomplishments

Activity: Program Management (Title III of the Public Health Service Act)

1974			1975	
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
266	$6,544,000	Indefinite	266	$9,619,000

Purpose: This activity provides top management, staff services, and Regional Offices staff to assure the desired direction and development of the Preventive Health Services programs' goals and objectives.

Explanation: Executive direction of the various programs is strengthened by sophisticated planning and analysis in terms of mission accomplishment and managerial effectiveness. The Regional Offices assist and serve State and local health agencies and community groups in activities at the local level which are a part of national coordinated preventive health programs.

Accomplishments in 1974: The necessary staffing was provided for planning, directing, and evaluating all program activities. Management activities throughout the Center were directed, coordinated, assessed, and assured consideration of management implications in program decisions. The Regional Offices' staff provided consultation, assistance and services to State and local health agencies with respect to grant supported programs for disease control, urban rat control, and prevention of lead poisoning in children, and served as the focal point for the review of State plans and grants for the control of occupational diseases and accidental work injuries.

Objectives for 1975: Effective and efficient program direction, staff services, and regional office support for Preventive Health Services programs will be provided. The first full year's operation of the decentralized agency accounting system will be accomplished. Cost advisory services will be provided on all negotiated contracts and the Center will fulfill its increased responsibilities within the DHEW personnel system.

New Positions Requested

	1975		
	Grade	Number	Annaul Salary
Disease control			
Disease investigations, surveillance & control			
Medical Officer	GS-14	1	$23,088
Medical Officers	GS-13	2	39,400
Mathematical Statistician	GS-12	1	16,682
Mathematical Statistician	GS-11	1	13,996
Statistical Assistant	GS-09	3	34,842
Clerical Assistant	GS-05	2	15,388
		10	143,396
Laboratory improvement			
Supervisory Research Medical Officer	GS-14	1	23,088
Supervisory Research Microbiologist	GS-14	1	23,088
Medical Officer	GS-14	1	23,088
Microbiologist	GS-13	1	19,700
Research Microbiologist	GS-13	1	19,700
Chemist	GS-11	2	27,992
Medical Technologist	GS-09	2	23,228
Administrative Clerk	GS-05	1	7,694
		10	167,578
Occupational health			
Direct operations			
Epidemiologist	GS-15	1	26,898
Toxicologist	GS-15	1	26,898
Scientist	GS-14	5	115,440
Toxicologist	GS-14	2	46,176
Medical Officer	GS-14	2	46,176
Health Physist	GS-14	1	23,088
Biological Scientist	GS-13	2	39,400
Medical Officer	GS-13	1	19,700
Safety Engineer	GS-13	1	19,700
Chemist	GS-12	3	50,046
Safety Engineer	GS-11	2	27,992
Technical Information Specialist	GS-11	1	13,996
Technical Writer	GS-09	1	11,614
Administrative Assistant	GS-06	2	17,144
Secretary	GS-05	2	15,388
Clerk-typist	GS-04	4	27,528
Clerk-typist	GS-03	2	12,256
		33	539,440

New Positions Requested - continued

	1975		
	Grade	Number	Annual Salary
Commissioned Officers			
Full grade			
Biochemist		1	14,252
Bioengineer		1	14,252
Pathologist		1	19,259
Psychologist		1	19,259
Sanitary Engineer		1	14,252
		5	81,274
Senior assistant grade			
Biochemist		1	12,438
Chemist		1	12,438
		2	24,876
Total new positions, all activities.		60	956,564

WEDNESDAY, APRIL 3, 1974.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

WITNESSES

DR. ROGER O. EGEBERG, INTERIM ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

KARST J. BESTEMAN, ACTING DEPUTY ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

JOSEPH R. LEONE, ACTING EXECUTIVE OFFICER, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

JOHN D. MAHONEY, ACTING DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

DR. THOMAS F. A. PLAUT, COUNSELOR TO THE DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

DR. FRANCIS N. WALDROP, DIRECTOR, DIVISION OF MANPOWER AND TRAINING PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH

DR. MORRIS E. CHAFETZ, DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

KENNETH L. EATON, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

MARTIN K. TRUSTY, EXECUTIVE OFFICER, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

DR. ROBERT L. DuPONT, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

DR. JOHN C. SCANLON, ACTING DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE

JOHN M. PROCTOR, EXECUTIVE OFFICER, NATIONAL INSTITUTE ON DRUG ABUSE

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Object Classification (in thousands of dollars)

Identification code 09-30-1361-0-1-650		1973 actual	1974 est.	1975 est.
	Direct obligations:			
	Personnel compensation:			
11.1	Permanent positions	31,292	33,082	27,038
11.3	Positions other than permanent	2,798	2,773	2,636
11.5	Other personnel compensation	660	617	531
	Total personnel compensation	34,750	36,472	30,205
12.1	Personnel benefits: Civilian	3,618	3,576	3,013
21.0	Travel and transportation of persons	2,338	2,528	2,381
22.0	Transportation of things	234	203	185
23.0	Rent, communications, and utilities	2,344	2,423	4,646
24.0	Printing and reproduction	977	1,111	1,070
25.0	Other services	53,465	93,011	89,429
26.0	Supplies and materials	2,148	2,203	1,843
31.0	Equipment	1,532	2,002	1,869
41.0	Grants, subsidies, and contributions	417,134	826,387	557,721
	Total program costs, funded	518,540	969,916	692,362
94.0	Change in selected resources	128,042	---------	---------
	Total direct obligations	646,582	969,916	692,362
	Reimbursable obligations:			
25.0	Other services	1,218	140	---------
99.0	Total obligations	647,800	970,056	692,362

Personnel Summary

	1973 actual	1974 est.	1975 est.
Total number of permanent positions	2,213	1,453	1,512
Full-time equivalent of other positions	352	343	334
Average paid employment	2,405	2,177	1,795
Average GS grade	7.4	7.7	10.2
Average GS salary	$14,636	$16,834	$18,374

Program and Financing (in thousands of dollars)

Identification code 09-30-1361-0-1-650	1973 actual	1974 est.	1975 est.
Program by activities:			
Direct program:			
1. General mental health:			
(a) Research	71, 492	109, 454	84, 468
(b) Training	56, 272	128, 021	65, 101
(c) Community programs:			
(1) Construction	5, 160	34, 250	---------
(2) Staffing	127, 712	155, 513	172, 053
(3) Children's services	15, 005	19, 000	26, 844
(d) Management and information	19, 323	23, 398	16, 753
Subtotal	294, 964	469, 636	365, 219
2. Drug abuse:			
(a) Research	24, 671	34, 056	34, 000
(b) Training	9, 506	15, 138	9, 969
(c) Community programs:			
(1) Project grants and contracts	101, 286	192, 649	122, 000
(2) Grants to States	12, 311	15, 000	35, 000
(d) Management and information	9, 152	15, 899	15, 646
Subtotal	156, 926	272, 742	216, 615
3. Alcoholism:			
(a) Research	6, 025	13, 189	10, 405
(b) Training	4, 229	12, 224	1, 947
(c) Community programs:			
(1) Project grants and contracts	18, 993	106, 265	32, 051
(2) Grants to States	20, 397	75, 600	45, 600
(d) Management and information	8, 109	11, 107	9, 863
Subtotal	57, 753	218, 385	99, 866
4. Buildings and facilities	---------	---------	200
5. Program direction	8, 897	9, 153	10, 462
Total direct program	518, 540	969, 916	692, 362
Reimbursable program:			
1. General mental health:			
(a) Research	55	---------	---------
(d) Management and information	114	---------	---------
Subtotal	169	---------	---------
2. Drug abuse: (a) Research	157	140	---------

	3. Alcoholism:			
	(c) Community programs:			
	1. Project grants and contracts	100	....	....
	(d) Management and information	792	....	....
	Subtotal	892	....	....
	Total, reimbursable program	1,218	140	....
	Total program costs, funded [1]	519,758	970,056	692,362
	Change in selected resources (undelivered orders)	128,042	....	....
10	Total obligations	647,800	970,056	692,362
	Financing:			
	Receipts and reimbursements from:			
11	Federal funds	−1,213	−140	....
14	Non-Federal sources	−5	....	....
21	Unobligated balance available, start of year	−25,609	−31,879	−200
22	Unobligated balance transferred from accounts	....	−6,627	....
23	Unobligeted balance transferred to other accounts	699	6,427	....
24	Unobligated balance available, end of year	31,879	200	....
25	Unobligated balance lapsing	150,191	2,921	....
	Unobligated balance restored	....	−147,909	....
	Budget authority	**803,742**	**793,049**	**692,162**
	Budget authority:			
40	Appropriation	803,823	815,975	692,162
	Withheld from obligation and expenditure (Public Law 93–192)	....	—9,567	....
41	Transferred to other accounts	−81	−164	....
43	**Appropriation (adjusted)**	**803,742**	**806,244**	**692,162**
45	**Proposed transfer for pay raises**	....	**−13,195**	....
	Relation of obligations to outlays:			
71	Obligations incurred, net	646,582	969,916	692,362
72	Obligated balance, start of year	590,069	667,001	1,003,111
73	Obligated balance transferred, net	....	3,545	−161
74	Obligated balance, end of year	−667,001	−1,003,111	−916,906
77	Adjustments in expired accounts	−2,666	....	....
90	Outlays	566,984	637,351	778,406

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[1] Includes capital outlay as follows: 1973, $1,532 thousand; 1974, $2,002 thousand; 1975, $1,869 thousand.

NOTES

Excludes $610 thousand in 1975 for activities transferred to (in thousands of dollars):

	1975
Office of Assistant Secretary, Health	413
Office of Secretary, HEW	197

Comparable amounts in 1973 ($610 thousand) and 1974 ($610 thousand) are included above.

Includes $378 thousand in 1975 for activities previously financed from (in thousands of dollars):

	1973	*1974*
Departmental Management	3	3
Office of the Assistant Secretary, Health	37	37
FDA, NIH, HRA, HSA, CDC, and OASH	138	138
Buildings and facilities, HSMHA	4,731	5,700

Mr. FLOOD. The committee will come to order.

Now we have the Alcohol, Drug Abuse, and Mental Health Administration. The presentation will be made by Dr. Roger O. Egeberg, the interim Administrator.

We have a biographical sketch of you, Dr. Egeberg, we will place in the record at this point.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH OF ROGER O. EGEBERG, M.D.

Position: Special Consultant to the President on Health Affairs, Special Assistant to the Secretary for Health Policy.

Birthplace and date: Chicago, Ill., November 13, 1903.

Education: Cornell University, Ithaca, N.Y., Bachelor of Arts 1925; Northwestern University School of Medicine, Chicago, Ill., doctor of medicine 1929; Intern, Chicago Wesley Memorial Hospital, 1928–1929; Resident, Internal Medicine, Passavant Memorial Hospital, Chicago, Ill., 1929–30; Resident, Internal Medicine, University of Michigan Hospital, Ann Arbor, Mich., 1930–32.

Experince: Special Consultant to the President on Health Affairs, July 1971 to present; Special Assistant to the Secretary for Health Policy, U.S. Department of Health, Education, and Welfare, July 1971 to present; Assistant Secretary for Health and Scientific Affairs, U.S. Department of Health, Education, and Welfare, 1969–71; Dean, University of Southern California School of Medicine, Los Angeles, Calif., 1964–69; Medical Director, Department of Charities, Los Angeles County, Los Angeles, Calif., 1959–64; Professor of Medicine, University of Southern California, Los Angeles, Calif., 1956–69; Medical Director, Los Angeles County General Hospital, Los Angeles, Calif., 1956–59; Clinical Professor, College of Medicial Evangelists (now Loma Linda University), Loma Linda, Calif., 1956–64; Chief of the Medical Service and Clinical Director of the Veterans' Administration's Wadsworth General Medical and Surgical Hospital, Los Angeles, Calif., 1946–56; Clinical Instructor and Assistant Clinical Professor, Western Reserve University School of Medicine, Cleveland, Ohio, 1932–42; Private practice, Internal Medicine, Cleveland, Ohio, 1932–42.

Military Service: Major to colonel, Medical Corps, U.S. Army, 1942–46; personal physician and aid-de-camp to General of the Army Douglas MacArthur, 1944–45; Decorated with Bronze Star, Legion of Merit, and St. Olaf's Medal (Norway).

Professional Organizations: Diplomat, American Board of Internal Medicine; Fellow, American College of Physicians; Member: Los Angeles, County, Calif. and American Medical Associations, American Clinical and Climatological Association, Los Angeles Academy of Medicine, Pacific Interurban Clinical Club, California Society of Internal Medicine, Alpha Omega Alpha, Phi Kappa Phi.

Committees Commissions: Chairman, California Governor's Committee for the Study of Medical Aid and Health, 1959–60; Member, President's Ad Hoc Panel on Drug Abuse, 1962; Member, President's Advisory Commission on Narcotic and Drug Abuse, 1963; Member, California State Board of Public Health, 1961–68; President, 1966–68; Chairman, California Committee on Regional Medical Programs; Chairman, Los Angeles County Medical Reorganization Planning Committee; Member, National Cancer Advisory Council, 1964–68; Member, Special Medical Advisory Group to the Veterans' Administration, 1966–69; Chairman, 1968–69; Project Director, Office of Economic Opportunity, Neighborhood Comprehensive Health Care Clinic, Los Angeles, Calif., 1965–69.

CURRICULUM VITAE—MORRIS EDWARD CHAFETZ, DOCTOR OF MEDICINE

Birthplace and date: Worcester, Mass., April 20, 1924.

Marital status: Married, three children.

Education: Tufts College, Somerville, Mass., Bachelor of Science 1944; Tufts Medical School, Boston, Mass., Doctor of Medicine 1948; Intern, U.S. Marine Hospital, Detroit, Mich., 1948–49; Resident Psychiatrist, State Hospital, Howard, R.I., 1949–51.

Board certification: Diplomate, American Board of Psychiatry and Neurology.

Professional training and appointments: 1951–52, fellow in neurophysiology, Instituto Nacional de Cardiologia, Mexico, DF; 1952, psychiatrist, U.S. Coast Guard, Cape May, N.J., 1952–54, clinical and research fellow in psychiatry, Massachusetts General Hospital; 1953–54, research fellow in psychiatry, Harvard Medical School; 1954–57, assistant in psychiatry, Harvard Medical School; 1954–55, clinical assistant in psychiatry, Massachusetts General Hospital; 1955–57, assistant in psychiatry, Massachusetts General Hospital; 1957–58; assistant psychiatrist, Massachusett General Hopital; 1957–61, instructor in psychiatry, Harvard Medical School; 1957–68, director, alcohol clinic, Massachusetts General Hospital; 1958–64, associate psychiatrist, Massachusetts General Hospital; 1958–70, consulting psychiatrist, Massachusetts Eye and Ear Infirmary; 1959–64, special consultant to National Institute of Mental Health; 1961–64, clinical associate in psychiatry, Harvard Medical School; 1961–68, director, acute psychiatric services, Massachusetts General Hospital; 1963–70, research consultant, Memorial Hospital, North Conway, N.H.; 1964–68, assistant clinical professor in psychiatry, Harvard Medical School; 1964–70, psychiatrist, Massachusetts General Hospital; 1968–70, associate clinical professor of psychiatry, Harvard Medical School; 1968–70, director, clinical psychiatric services, Massachusetts General Hospital; 1970–71, acting director, division of alcohol abuse and alcoholism, National Institute of Mental Health; 1971 to present, director, National Institute on Alcohol Abuse and Alcoholism, National Institute of Mental Health.

Memberships: American Psychiatric Association: Committee on Therapy, 1964, Task Force on Alcoholism and Drug Abuse, 1969–70, chairman, Task Force on Alcoholism, 1970–72; American Orthopsychiatric Association; American Medical Association Committee on Alcoholism and Drug Dependence, 1965–72; American Hospital Association; Advisory Committee on Mental Health Care Institutions and Service, 1968–70; Advisory Committee on Hospital Care of the Alcoholic, 1969–70; American Association for the Advancement of Science; Governor's Advisory Council on Mental Health, Massachusetts, 1964–70; Group for the Advancement of Psychiatry Mental Health Services Committee, 1963 to present; NIMH Ad Hoc Review Board on Research in Alcoholism, 1958–61; Subcommittee on Alcoholism, Massachusetts Mental Health Planning Project, 1963; Secretary of Health, Education, and Welfare Planning Committee on Alcoholism Programs, 1963; Sigma Xi, consultant, Student Association for the Study of Hallucinogens, 1968–70; Advisory Committee on Alcoholism of the Attorney General's Office of Massachusetts, 1969–70; Corresponding member of the Institute for Study and Prevention of Alcoholism in Zagreb, 1971 to present; consultant, Pan American Health Organization, 1972 to present.

Editorial appointments: Medical Insight, Editorial Advisory Board; Mental Health Digest, Editorial Advisory Board; Psychiatric Opinion, Editorial Board; Journal of Nervous and Mental Disease, guest editor; Evaluation, Editorial Review Board.

Honors and other special scientific recognition: Maudsley Bequest Lecturer, University of Edinburgh, Edinburgh, Scotland, 1969; Moses Greeley Parker Lecturer, 1969; Louis and Amelia Block Lecturer, Mount Zion Hospital and Medical Center, San Francisco, Calif., 1969; International Film and TV Festival of New York Gold Medal, 1972.

BIOGRAPHIC SKETCH OF THOMAS F. A. PLAUT

Education: B.A., 1949, Swarthmore College; Ph. D. (clinical psychology), 1956, Harvard, Department of Social Relations; M.P.H., 1957, Harvard School of Public Health.

Professional experience: 1956–61, staff of the community mental health program, Harvard School of Public Health; 1961–62, director of the alcoholism program, Massachusetts Department of Public Health; 1962–67, research associate (Cooperative Commission on the Study of Alcoholism), Institute for the Study of Human Problems, Stanford University, California; 1967–69, Assistant Chief, National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, U.S. Department of Health, Education, and Welfare; 1969–71, Director, Division of Manpower and Training Programs, National Institute of Mental Health, U.S. Department of Health, Education, and Welfare; 1971–72, Associate Director for Program Coordination, National Institute of Mental Health, U.S. Department of Health, Education, and Welfare; 1972 to present, Counselor to the Director, National Institute of Mental Health, U.S. Department of Health, Education, and Welfare.

Publications (with Bert Kaplan): "Personality in a Communal Society: An Analysis of the Mental Health of the Hutterite," University of Kansas Press, Social Science Studies, 1956, Lawrence, Kans.; "Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism," Oxford University Press, 1967, New York City; (with Glasscote, R. et al.): "The Treatment of Alcoholism: A Study of Programs and Problems," Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Washington, D.C., 1967; three dozen papers in various professional and scientific journals.

Other information: Lecturer in behavioral sciences, Johns Hopkins School of Hygiene and Public Health (1967 to present); nonresident lecturer, department of Health Development, University of Michigan School of Public Health (1970 to present); associate editor, Journal of Health and Social Behavior (1968 to present); consulting editor, Community Mental Health Journal (1967 to present).

CURRICULUM VITAE—ROBERT L. DUPONT, M.D.

Date of Birth: March 25, 1936 (Toledo, Ohio).

Current full-time positions: Director, Special Action Office for Drug Abuse Prevention, Executive Office of the President; Director, National Institute for Drug Abuse, Department of Health, Education, and Welfare.

Education: June 1954, Graduated from East Denver High School; June 1958, B.A., Emory University, Atlanta, Ga., June 1963, M.D., Harvard Medical School, Boston, Mass.

Postgraduate training: 1963–64, Medical Intern, Cleveland Metropolitan General Hospital, Western Reserve Medical School, Cleveland, Ohio; 1964–66, Psychiatric Resident and Teaching, Fellow in Psychiatry, Massachusetts Mental Health Center, Harvard Medical School, Boston, Mass.; 1966–68, Clinical Associate, Laboratory of Clinical Sciences, National Institute of Mental Health, Bethesda, Md.

Brief chronology of employment: 1959 (2 months), Epidemiology Trainee, California Department of Public Health, Berkeley, Calif.; 1961 (3 months), Research Assistant, Tuberculosis Laboratory, Communicable Disease Center, Atlanta, Ga.; 1964–65, Psychiatrist, Washington Hospital; Jamaica Plains, Mass. (part-time position); 1965–66, Senior Psychiatrist, Massachusetts Department of Corrections, Norfolk Prison, Norfolk, Mass. (part-time position); 1968–70, Research Psychiatrist and Acting Associate Director for Community Services, District of Columbia Department of Corrections, Washington, D.C.; 1970–73, Administrator, Narcotics Treatment Administration, Department of Human Resources, Government of the District of Columbia, Washington, D.C.

Consultantships and board memberships: 1967–68, Consultant on Research and Development, District of Columbia Department of Corrections, Washington, D.C.; 1968–71, Consultant, Child Research Branch, National Institute of Mental Health, Bethesda, Md.; 1971–72, Consultant, American Bar Association, Special Committee on Crime Prevention and Control, Washington, D.C.; 1971–72, Member, The Armed Forces Epidemiological Board, Committee on Drug Abuse, Washington, D.C.; 1971–73, Consultant to the Food and Drug Admintration, Bureau of Drugs, Rockville, Md.; 1971–73 Member, Board of Directors, Center for Correctional Justice, Washington, D.C.; 1971–73, Consultant to the Special Action Office for Drug Abuse Prevention, The White House, Washington, D.C.; 1971–73, Consultant, Veterans Administration, Washington, D.C.; 1972–73, Member, National Advisory Council on Drug Abuse Prevention, A Presidental Appointment, Washington, D.C.; 1972–73, Member, Drug Abuse Task Force, National Advisory Commission on Criminal Justice Standards and Goals, Department of Justice, Washington, D.C.; 1972 to present, Member, Washington Junior League Advisory Committee, Washington, D.C.; 1972 to present, Member, Board of Directors, Washington Society for the Performing Arts.

Honors: 1971–72, Melvin C. Hazen Award to the Outstanding Young Man in the District of Columbia Government (presented by the Downtown Jaycees); 1973 to present, Meritorious Service Award, District of Columbia Government.

Military service: 1966–68, Surgeon (Major), U.S. Public Health Service, National Institute of Mental Health, Bethesda, Md.

Societies: District of Columbia Medical Society, Washington Psychiatric Society, Washington Area Council on Alcoholism and Drug Abuse, American Psychiatric Association, American Correctional Association, National Council on

Crime and Delinquency, Medical Corrective Association, American Academy of Psychiatry and Law, American Public Health Association.

Medical license: District of Columbia, Maryland, Massachusetts, California.

Certification: Certified in psychiatry by the American Board of Psychiatry and Neurology, 1970.

Faculty appointments: 1964–66, Teaching Fellow in Psychiatry, Harvard Medical School; 1970–72, Assistant Clinical Professor of Psychiatry, George Washington University Medical School; 1972 to present, Associate Clinical Professor of Psychiatry, George Washington Medical School.

CURRICULUM VITAE—BERTRAM S. BROWN, M.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, ASSISTANT SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE

Date and place of birth: Brooklyn, New York, January 28, 1931.

Marital status: Married 1952, four children.

Education: June 1952, B.A., Brooklyn College; June 1956, M.D., Cornell University Medical College; June 1960, M.P.H., Harvard University School of Public Health.

Postgraduate training: July 1956–June 1957, Intern, Yale University School of Medicine, Department of Pediatrics; June 1957–June 1960, Resident and teaching fellow (psychiatry) Harvard Medical School (Boston Psychopathic Hospital), Massachusetts Mental Health Center.

Certification: Diplomate, American Board of Psychiatry and Neurology, 1963.

Employment: July 1958–November 1959, Senior psychiatrist, division of legal medicine, Commonwealth of Massachusetts; Director of Psychiatry, Norfolk Prison Colony; April 1960 to present, U.S. Public Health Service, National Institute of Mental Health: April 1, 1960–July 4, 1961, Staff psychiatrist, Mental Health Study Center; July 5, 1961–October 14, 1963, Special assistant for program, extramural programs; October 15, 1963–March 22, 1964, Special Assistant for program, Office of the Director; March 23, 1964–June 5, 1966, Chief, Community Mental Health Facilities Branch; June 9, 1966–December 31, 1966, Associate Director for Mental Health Service programs; January 1, 1967–June 2, 1970, Deputy Director, National Institute of Mental Health; June 3, 1970 to present, Director, National Institute of Mental Health; October 1961–October 1962, Staff Director, President's Panel on Mental Retardation. (See: Report to the President, "A Proposed Program for National Action To Combat Mental Retardation," PPMR, GPO, Washington, D.C., October 1962; December 1962–July 1963, Deputy Special Assistant to the President for Mental Retardation. The White House; November 1970–September 1972, Special Assistant to the Secretary of HEW for Drug Abuse Prevention; November 1971–July 1973, Deputy Administrator for Mental Health, Health Services and Mental Health Administration, HEW.

Special missions: September 1972, Headed National Institute of Mental Health delegation to the Soviet Union; May 1973, Headed National Institute of Mental Health delegation to Japan for U.S.–Japan mental health mission;

Consultant (White House): June 1961 to present, President's Committee on Employment of the Handicapped; July 1963–July 1966, Office of the Special Assistant to the President for Mental Retardation; July 1966–July 1967, President's Commission on the Administration of Law Enforcement and Justice; April 1968–November 1969, President's Commission on the Causes and Prevention of Violence; January 1970–June 1970, Executive Secretary, the President's Task Force on the Mentally Handicapped.

Consultant (partial listing): October 1959–April 1960, Research Consultant, Cambridge Services for Retarded Children, Children's Bureau Demonstration project, Cambridge Health Department, Mass.; 1960–61, Outdoor Resources Recreation Review Commission, Washington, D.C.; 1962 to present, Technical Advisory Board, Maurice Falk Medical Foundation, Pittsburgh, Pa.; April 1969 to present, Task Force to develop policy recommendations on health aspects of malnutrition, United States Public Health Service; June 1969 to present, U.S. Committee on the International Congress on Social Welfare; 1970 to present, Hogg Foundation National Advisory Council.

Academic teaching appointments: July 1958–June 1960, Field Work Supervisor, Department of Social Relations, Harvard University; 1958 and 1959, Faculty, Boston University Institute on "Rehabilitation of the Emotionally Handicapped"; January 1962–72, Associate Clinical Professor of Psychiatry, George Washington University Medical School; January 1971 to present, Clinical Professor of Psychiatry and Behavioral Sciences, George Washington University Medical School; January 1965 to present, Senior Faculty, Washington School of Psychiatry.

Editorial boards: April 1971 to present, Editorial Board, Journal of Autism and Childhood Schizophrenia; July 1970 to present, Chairman, Editorial Board, Mental Health Digest; July 1970 to present, Editorial Board, Medical Insight.

Military service: U.S. Air Force, May 1957 to March 1960; first lieutenant (inactive Reserve).

Honors and awards: Phi Beta Kappa (Brooklyn College), Alpha Omega Alpha (Cornell), Delta Omega (Harvard); Commendation Medal, U.S. Public Health Service Comimssioned Corps, January 1967; Arthur S. Flemming Award, February 1969; Maryland Mental Health Citizens Award, May 1969; Anchor Club Award, June 1972; Meritorious Service Medal, U.S. Public Health Service, June 1973.

Professional societies: American Board of Psychiatry and Neurology (Diplomate), American Psychiatric Association (Fellow), American Public Health Association (Fellow), American Orthopsychiatric Association (Fellow), Council on National and International Affairs (Fellow), American College of Psychiatrists (Fellow), American Sociological Association, American Association on Mental Deficiency, American Medical Association.

INTRODUCTION OF WITNESSES

Mr. Flood. Do you have anybody with you that you want us to know?

Dr. Egeberg. Yes; I would like to introduce several of the people with me.

On my right is Mr. Karst Besteman, Acting Deputy Administrator of the Alcohol, Drug Abuse, and Mental Health Administration, and on my left is Mr. Joseph Leone, Acting Executive Officer.

Behind me are the three Institute Directors, Dr. Morris Chafetz, the Director of the National Institute of Alcoholism and Alcohol Abuse, and Dr. Robert DuPont, Director of the National Institute of Drug Abuse, and Dr. Tom Plaut, acting in place of Dr. Bertram Brown for the first hour. Dr. Brown had to appear in hearings before Senator Pastore about violence on television. He had a longstanding request, and he was promised he could get here by 11. In the meantime Dr. Plaut, Counselor to the Director, will handle any questions on the National Institute of Mental Health.

I think as they speak the directors may want to introduce other individuals.

Mr. Flood. Of course you know the practice here. This is your first appearance in this theater. You haven't been here during the recent hearings but we hope to maintain the intimacy of our relationship in the old room in the Capitol. Don't let this arm-length business confuse you anyway. It hasn't anybody else so far. If any of these people wish to volunteer or if you want to call on anybody, you do that.

I see you have a prepared statement. How do you want to handle this?

Dr. Egeberg. Would you like me to read it, sir?

Mr. Flood. It is your show.

Dr. Egeberg. I think I would. I think it sets the stage.

OPENING STATEMENT

Mr. Chairman and members of the committee, it is a pleasure for me to have the opportunity to appear before you to speak about the programs of the Alcohol, Drug Abuse, and Mental Health Administration, the newest agency in the Public Health Service. I have with me today the directors of the three Institutes of ADAMHA.

REORGANIZATION

The Alcohol, Drug Abuse, and Mental Health Administration was created from programs which previously were a part of the National Institute of Mental Health. Reorganization of these components into a tri-Institute Administration was designed to give each program—alcoholism, drug abuse, and mental health—the opportunity to stand on its own feet, dominated by its own needs and not by any other program, and with responsibility for its own resources and accomplishments.

In keeping with the heightened importance of alcoholism and drug abuse in our country—and today both have an intolerable impact—the organizational pattern of the agency provides greater access to planning and decisionmaking at all levels that influence activities and affect progress in these areas. At the same time, the new organization maintains the close ties that should exist between alcoholism, drug abuse, and mental health programs.

Inroads already made on alcohol problems, drug abuse, and mental illness are extremely gratifying, and the promise of further advancements in the foreseeable future is genuine. Nevertheless, the scope of these problems facing us today remains enormous and calls for our continued dedication and effort.

DRUG ABUSE

While we have witnessed hopeful indicators that the rapid escalation in heroin abuse that began in the middle 1960's may be slackening, heroin addiction persists as a major problem affecting several hundred thousand persons. Even more worrisome to many persons involved in preventing and controlling the misuse of drugs is the growing phenomenon of polydrug abuse.

ALCOHOL ABUSE AND ALCOHOLISM

Alcohol abuse and alcoholism cause suffering and destruction to individuals, wreak havoc on families, and waste vast financial and human resources. As many as 9 million Americans are problem drinkers or alcoholic persons. Each affects adversely an average of 4 others, adding some 36 million victims.

MENTAL ILLNESS

The major mental illnesses continue to strike the young and old alike. In 1972 there were still 133,000 patients with chronic schizophrenia in our public mental hospitals. Estimates of the prevalence of the depressive illnesses point to a rate of about 3 percent—6 million people—in the United States.

The mental health of children remains a serious and especially poignant problem. Over 40,000 children under the age of 20 are in public mental hospitals. Childhood schizophrenia remains an enigma. Each year, more than 1 million 13- and 14-year-olds run away from home. One in every six male youths, it is estimated, will be referred to a juvenile court before his 18th birthday. Close to 26 percent of all arrests for serious crimes involve persons under age 15; close to 50 percent involve persons under 18.

An estimated 10 to 25 percent of the aged living in the community have some degree of mental impairment and need help.

To deal successfully with this broad spectrum of human problems, I am pleased to report that the agency has underway a wide range of research to uncover new knowledge, and has supported treatment and training programs to make urgently needed services available.

For purposes of organization and clarity, I would like to briefly describe our progress and plans separately by Institute. It goes without saying that interrelationships and cooperative endeavors abound among the programs of the three Institutes.

TREATMENT AND PREVENTION OF ALCOHOLISM

Advances in the treatment and prevention of alcoholism—and equally so with respect to drug abuse and mental illness—depend on a continuing flow of new information from research and demonstration projects. The National Institute on Alcoholism in the current fiscal year is supporting more than 100 research investigations ranging from studies of the etiology of liver cirrhosis and other alcohol-related disease, to careful examination of the withdrawal syndrome and its treatment.

In one Institute-supported research project, the investigators have shown that children of alcoholic parents have a higher incidence of adult alcoholism than do children with nonalcoholic parents. Evidence of this predisposition is presently limited to boys, but girls are now being studied. This project offers us an excellent opportunity to gather data on the relative contribution of genetic and environmental factors in alcoholism.

A most valuable recent finding from alcohol research is that cirrhosis and other liver damage results directly from the toxic effects of alcohol. When I was teaching we used to think it was due to the absence of food, that people would drink so much they wouldn't eat, and failed to get their vitamins, minerals, and proteins. Now it looks as if it is the direct toxic effect of alcohol.

Mr. **Flood**. You don't believe in the two martinis and hors d'oeuvres for appetizers?

Dr. **Egeberg**. It is very important to take the appetizers.

COMMUNITY BASED ALCOHOL SERVICES

The chief immediate goal of the Alcohol Institute has been and remains to make the best possible treatment and rehabilitation services available at the community level. Almost 700 community programs will have received Institute support by the end of fiscal year 1974. Federal assistance has demonstrated the feasibility and effectiveness of community-based alcoholism services and we are turning to promising new initiatives.

During fiscal year 1975, we propose to place a major focus on support for the implementation in the States of the "Uniform Alcoholism and Intoxication Treatment Act," recommended for enactment in all 50 States by the National Conference of Commissioners on Uniform State Laws. This model law regards alcohol abuse and alcoholism as public health problems and removes them from the criminal justice system while in no way altering the provisions of a State's criminal law that protect public safety. Our budget for alcohol programs for the coming year includes funds for project grants to help States implement the uniform act, thus enabling them to effect the shift from incarceration to treatment for many alcoholic persons.

RECOVERY OF BENEFITS FOR TREATMENT OF ALCOHOLISM FROM PRIVATE HEALTH INSURANCE

Another major priority program in NIAAA will involve activities designed to bring about an increased recovery of benefits from the private health insurance sector for the treatment of alcoholism and alcohol-related problems. The Institute, through a contract with the Joint Commission on Accreditation of Hospitals, is developing standards and accreditation procedures for alcoholism treatment programs, a step essential to the recognition by private carriers of such programs from the point of view of benefit payments. At the community level, in support of the recovery of insurance benefits, the Institute plans to award incentive contracts to profitmaking institutions for organizing and establishing alcoholism treatment programs in private industry, which can sucessfully solicit third-party payments for such treatment. The NIAAA believes that these organizations can become self-sufficient after an initial 2-year period of Federal support. This project will greatly advance the provision of alcoholism treatment and rehabilitation services for employees in private industry.

It might be well to point out at this point, sir, that 90 percent of alcoholics are employed.

TREATMENT OF DRUG ABUSE

I am happy to report that in the field of drug abuse, our goal of making treatment available for all addicts who want it has been achieved. Waiting lists for treatment have been virtually eliminated. We now have a total funded treatment capacity of 95,000 in 312 community programs supported by the National Institute on Drug Abuse, enough capacity to treat up to 161,000 individuals annually by 1975.

During the current fiscal year the Institute has been working toward improving the quality of services provided, and emphasizing evaluation and demonstration projects. Simultaneously, a shift of responsibility for prevention, treatment, and rehabilitation from the Federal level to the States has been initiated. Major attention is being given to preparing State and local agencies to assume this responsibility and execute it through an approved State plan with formula grant support.

Of increased significance as the Federal-State partnership emerges will be our drug abuse treatment demonstration grant program, which is designed to evaluate and demonstrate effective models of service delivery. Other continuing contributions will come from the National Training System being developed by the Drug Institute. The purpose of the system is to consolidate and improve ongoing manpower activities of both Institute and other programs.

Although we can point with a certain pride to our present state of readiness to treat any and all addicts who want treatment and seek it, we will not be satisfied with this accomplishment. We are now in the process of adding a wholly new dimension to the total Federal treatment effort in a program of outreach. Rather than wait for addicts to come to treatment centers, we will actively reach out to penetrate the addiction underground and urge heroin abusers to enter treatment.

It now appears that the peak of increase in heroin addiction was reached in 1969 and that the rate of increase in the use of heroin is now declining. The rates of overdose death and property crime—regarded as significant indicators of the incidence of heroin addiction—have declined in most areas of the country. These are hopeful signs that the epidemic has been stemmed and that a turnaround is underway. They do not provide an occasion for any slackening of effort, however.

Ultimately, in the drug area as elsewhere among our multiple concerns, solutions to many problems depend on knowledge still to be gained through detailed and comprehensive research. To develop this information, NIDA supports a wide spectrum of research which ranges from investigating psychosocial and epidemiological factors influencing drug abuse to studying the basic chemistry of abused substances.

As a specific example, continued research on the mechanisms of opiate action and the recent identification of opiate receptors in the brain by two Institute grantees offer exciting possibilities for the development of more effective narcotic antagonists, which are nonaddicting drugs which block the effects of heroin in the body.

If you take those drugs and later on you take heroin, you fail to get high. Human testing is now underway with naltrexone, one of the newest and most promising of the antagonists.

NATIONAL INSTITUTE OF MENTAL HEALTH

Let me now turn to the third major area of ADAMHA concerns. In the 28 years since the National Institute of Mental Health was established, Americans have faced many challenges in the mental health area. While the problems are far from solved, and while many challenges remain, there has been great progress and achievement.

Our catalog of successes is long and varied, and it is important to point to some of the achievements of a history of nearly three decades.

Where once there was an alarming annual increase in the number of hospitalized mental patients, during the past 20 years there has been a dramatic decline in public mental hospital populations.

Where once there was an alarming shortage of professional mental health manpower, the numbers of active psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses, along with the numbers of institutions offering training for them, have increased drastically.

COMMUNITY MENTAL HEALTH CENTERS

Where once there was only spotty and sometimes inadequate services available, 626 comprehensive community mental health centers have been funded in the last 10 years of which more than 530 will be in operation by June 30, 1975 serving a population of 60 million.

Where once there was fragmented or little research effort, there is now a national program focusing on a number of priority areas.

These are noteworthy achievements, but it is time to reassess the Federal role in several of these areas.

An example is the community mental health centers programs. In 1974, increased funding has allowed the NIMH to fund 86 new centers, bringing the total number of centers to the present 626 authorized. Continuation support of $172 million for basic staffing grants, as well as $26.8 million for specialized child mental health grants, is being requested for 1975.

In light of the recent expansion in the number of federally supported centers, it is believed this level is adequate to demonstrate the value of community-based delivery of mental health care.

It is proposed that this approach be absorbed by the regular health service delivery system, with greater reliance on operational funding from third-party reimbursements and State governments. Therefore, the budget does not request additional funds to make new staffing grant awards. Also for this reason, the community mental health center legislation, which expires June 30, 1974, is not proposed for extension.

MENTAL HEALTH MANPOWER

In the area of manpower, one of the cardinal missions of the NIMH has been the development of well-trained personnel to work in the mental health field.

This program has concentrated both on the training of individuals and upon the expansion of the numbers and capacities of institutions and departments needed to help educate people in the mental health area.

Over the years these efforts resulted in increased numbers of personnel in the professional disciplines; it also became clear that the need for services was growing at an even faster rate, and that the supply of professionals could never be sufficient.

Accordingly, programs were instituted to support the training of individuals to do research in the biological, clinical, and social aspects of mental illness, in order to arrive at a better understanding of its causes, and to provide more means of prevention, treatment, and care. Financial aid was also given to programs of continuing education for people working in the mental health field at all levels, and for the training of new types of mental health personnel, both professional and nonprofessional.

During the current year, new awards will be made, both in the areas of categorical training and in the newer time-limited training programs of an experimental and developmental nature. This latter program makes it possible for the Institute to use a portion of its funds in an experimental manner, to see which new methods are successful and which are not, to evaluate programs closely, and to act as a clearinghouse for the dissemination of information on training, and to use this information in the Institute's role as technical adviser to State and local authorities.

Here again it is felt that these programs have been developed to the point that Federal subsidies are no longer required—particularly in those fields for which there is relatively high earning potential.

Beginning in fiscal year 1975, all training grant activities of the NIMH—including support both for student stipends and teaching costs—will be gradually phased out. No new awards are projected for any training grants during fiscal year 1975.

In the Institute's research program, a decrease of appropriations is proposed, and pending a careful consideration of NIMH efforts, a minimal amount of new starts is planned.

NIMH RESEARCH PRIORITIES

Cutting across all the NIMH programs are priority areas to which the Institute is giving particular attention. Among these priorities are the research efforts that are directed to the mental health of children, problems of the aging, crime and delinquency, and minority mental health problems.

Adding still another dimension, and relating to all these efforts are specialized studies in the areas of schizophrenia and depression.

The Institute also has just completed a comprehensive study and evaluation of its entire research program, and has compiled a series of recommendations for future research efforts which it plans to assemble into a broad and long-range strategy.

This strategy will be developed in concert by many outstanding scientists, from the Institute staff, which has among its number a Nobel laureate, and from the scientific community outside the NIMH.

SUMMARY

Finally, the overall role of the National Institute of Mental Health is changing, and this is perhaps the greatest challenge of all. The Institute will no longer support service and training programs, but will concentrate on helping States and communities to plan, operate, and evaluate their mental health activities, while continuing its research efforts at the most responsible level possible.

In conclusion, Mr. Chairman, the appropriation request for alcohol, drug abuse, and mental health in 1975 is $692,162,000 as compared to a comparable appropriation of $792,617,000 in 1974. The decrease by Institute is $36,887,000 for NIMH, $26,841,000 for NIDA, and $38,043,000 for NIAAA. These decreases are offset by an increase of $1,316,000 in program direction which represents the partial cost of reimbursements to GSA for space rental.

That concludes my opening statement. The Institute Directors and I will be very happy to answer any questions, sir.

Mr. FLOOD. Mr. Smith has another hearing and I yield to him.

NIMH ACTIVITIES RELATED TO SEX CRIMES

Mr. SMITH. Just one question. I am sorry I have to go. I think this is one of the most important Institutes. They are all important but certainly this one represents more millions of people directly and indirectly than any other Institute.

I am very impressed with your statement but there is one thing I notice wasn't even mentioned. That has to do with sex crimes. I brought this up a few years ago. I wasn't at all satisfied with the answer and I don't know what all has been done since then. But you know sex crimes are increasing in the United States twice as fast as other crimes. We know that other agencies of Government have been totally unable to deal with them, that is to cure them. And the victims of course and the whole families of victims become mentally ill in many cases.

Dr. EGEBERG. Yes.

Mr. SMITH. If your agency can't do something about finding the reasons for sex crimes, ways so these people can discipline themselves to live in civilized society, I don't know who is going to do it. What are you doing, what can be done?

Dr. EGEBERG. I know since I came here there has been much discussion. I will ask Dr. Plaut.

Dr. PLAUT. Mr. Smith, this is a very serious and major problem which is being tackled in a variety of different ways by different parts of the National Institute of Mental Health. As you were asking your question two elements occurred to me immediately.

One is the one about child abuse because a proportion of child abuse clearly involves sex-related crimes. It is not in totality, and I don't think you were addressing all of those.

But we have during the last 2 or 3 years been working very closely with other parts of the Department of Health, Education, and Welfare, particularly the Office of Child Development, in the whole child abuse area.

The other element that immediately occurred to me, Mr. Smith, had to do with the question under what circumstances should a person who is charged with a crime be committed to a mental institution for an indeterminate period of time. This has become one of the complicated issues in society, around the balance between the protection of society and the safeguarding of individual rights.

Mr. SMITH. What about physical alteration as an alternative to incarceration?

Dr. PLAUT. The Department has for a number of years been supporting studies conducted at Johns Hopkins under the leadership of Dr. Money, who has in the past received both research and training support from NIMH, and he is currently supported by the National Institute of Child Health and Human Development. Dr. Money and his research team are conducting behavioral studies of children with sex organ abnormalities resulting from genetic or endocrine difficulties. It is unlikely, in my personal judgment, for a significant majority of the persons involved in sex crimes that surgery would really be the answer.

Mr. SMITH. Would you just expand for the record everything you can on this subject—what is being done, what has been done, what can be done, what should be done?

Dr. PLAUT. It will be a pleasure to provide that information for the record. I would prefer that if it is satisfactory to you.

[The information follows:]

NATIONAL INSTITUTE OF MENTAL HEALTH ACTIVITIES RELATED TO SEX AND VIOLENCE

In the area of violent sex crimes the National Institute of Mental Health has, for the past 3 years, been supporting a research project dealing with the social and psychological effects of rape on victims. Followup studies of a large sample of rape victims are being conducted in order to ascertain the impact of various aspects of criminal justice processing on the victims' m[illegible] functioning and post-rape adjustment. Information is also being obtain[illegible] facilitate more effective delivery of emergency health and mental health care as well as other followup services to rape victims. It is also expected that this research will lead to the development of a variety of training materials for law enforcement, health, and mental health, prosecutorial, and related personnel. Another component which is being added to this ongoing project pertains to the study of legal-evidentiary requirements necessary to substantiate accusations of rape.

The victim assault study just described grew out of a previously supported research project by the same investigator. The project was concerned with the development of group psychotherapy approaches for the treatment of sex offenders. The sexual offenders involved in this study included persons convicted or exhibitionism, pedophilia, voyeurism, and rape. The focus of the treatment was on the establishment of cohesiveness among peers in order to facilitate discussion of common problems; to dilute the offenders' intense reactions to authority and authority figures; and to resolve social and occupational problems leading to impulsive antisocial patterns of behavior.

Several other research projects pertaining to the assessment of victim needs and responses of community agencies in the delivery of mental health and other services to rape victims are currently being explored. Studies are also contemplated to learn more about rape offenders and their treatment. Finally, a monograph is presently being developed, in the crime and delinquency monograph series, on the topic of the various services and facilities needed for victims of rape.

In addition to the aforementioned studies dealing more directly with violent sex crimes, the National Institute of Mental Health has also been very active in studies dealing with various biological, behavioral, and social factors related to aggression and individual violent behavior. A broad range of research has been and continues to be supported in this particular area. The research efforts addressing this broad topic include: (1) study of genetic, perinatal, and psychophysiological factors, and their interaction with environment variables in the etiology of antisocial and aggressive behavior, (2) The development of improved diagnostic as well as treatment techniques for differentiating persons with aggressive lifestyles from those manifesting episodic aggressivity stemming from particular behavioral and psychiatric features (viz., epileptoid and hysteroid factors), (3) examinations of the relationship between aggressive and violent behaviors and repeated exposure to television and movie violence, (4) an effort to operationalize the concept of "dangerous" as used in mental health and criminal justice system handing of mentally disordered individuals, and (5) research aimed at the development of social learning concepts and intervention strategies in the treatment of social aggression among preadolescent boys.

Turning to another aspect of the problem of sex and violence, we need to learn more about how basic hormonal and neurological processes influence and interact in both sexual and aggressive behavior, before we can reach an understanding of the root causes of violent sex crimes. The National Institute of Mental Health is investigating the theory that injections of increased male sex hormones (testosterone) result in increased aggression in primates and other animals. Further research is underway to find out how testosterone levels change naturally during puberty and in different social situations involving aggression.

Another animal study will examine the effects of injecting the male sex hormone, androgen, on aggressive behavior. Also, an attempt will be made to find out whether certain brain lesions lead to aggression. If the investigator can show that brain lesions and androgenization both increase aggression, this would indicate that specific sites in the hypothalmus of the brain serve in parallel dual functions in sex and aggression. The role of the adrenal gland in the control of aggressive behavior is also being studied. Another project is examining the gonadal hormone effect in persons with sex problems, including sex offenders.

RELATIONSHIP BETWEEN ALCOHOL AND SEX CRIMES

Dr. CHAFETZ. Mr. Smith, if I may, one of the things that will be part of the report the Secretary will be making on alcohol and health to the Congress as mandated by the legislation that created the Alchohol, Drug Abuse, and Mental Health Administration has been a study of alcohol and violence and crime. I think that part of the findings will indicate that 50 percent of all violent crimes, sexual and otherwise, including battered child syndrome, are directly related to the abuse of alcohol. I think we may, by finally coming to grips with the alcohol problem of this country, come to grips directly and indirectly with the problem you are concerned about.

Mr. SMITH. Even if it is 50 percent and you take into consideration there are twice as many sex crimes as other crimes, you haven't dealt with enough of the real problem, just part of it. It seems to me the victims of sex crimes aren't organized like the victims of diseases and somebody has to start representing them.

Dr. EGEBERG. Thank you.

REORGANIZATION

Mr. FLOOD. Last year we called this the National Institute of Mental Health. This year it is called Alcohol, Drug Abuse, and Mental Health Administration. Has anything changed but the name?

Dr. EGEBERG. A study was conducted by people in-house and people outside of the Government as to the best organizational framework of the National Institute of Mental Health and appropriate location within the health complex. This was the final step in the reorganization of the previously existing Health Services and Mental Health Administration. There were three recommendations and the best choice was the one I feel was selected—a recommendation by the group that three institutes be created so that each subject, alcoholism, drug abuse, and mental health, could be equally visible both within Government and from outside the Government. The recommendation also provided for establishing the Alcohol Drug Abuse Mental Health Administration as a sixth health agency in recognition of the fact that the organization includes research, training and service components and therefore does not fit the mold of the other agencies.

Mr. FLOOD. Are these the reasons for the reorganization?

Dr. EGEBERG. These were the reasons why it was decided to do it this way.

Mr. FLOOD. Those are the reasons for the reorganization?

Dr. EGEBERG. They had to do something about HSMHA which was an ungainly collection of activities.

Mr. FLOOD. Remember I asked you what changed other than the name. What is the Alcohol, Drug Abuse, and Mental Health Administration doing that is different from what the National Institute of Mental Health is?

Dr. EGEBERG. Hopefully, it isn't doing anything different but it is allowing each Institute to focus exclusively on a subject which is of high priority and high interest in our country at the present time. There is great hope for what can be accomplished by the new organization. I think from that point of view, having alcoholism and drug abuse stand on a parity in a way with mental health has served a useful purpose.

Mr. FLOOD. That we know. That was going on in the old setup. What are the reasons for the reorganization? Why? Big deal. What are the reasons?

Dr. EGEBERG. The National Institute of Mental Health had under it both the alcoholism and drug abuse programs.

Mr. FLOOD. Yes.

Dr. EGEBERG. There was feeling that if these three programs could stand shouldder to shoulder to mental health they would be more effective.

.ɪr. **Flood.** At some time across the whole spectrum the handling of the problem of alcohol and alcoholism was formally officially recognized as disease. Is this part of the reorganization?

Dr. **Egeberg.** You mean to recognize alcoholism as a disease?

Mr. **Flood.** No, to reorganize what you have been doing before. Is that a reason for the reorganization?

Dr. **Egeberg.** What the reorganization has done——

Mr. **Flood.** What happened?

Dr. **Egeberg.** Instead of being under the very protective and supportive management of mental health, alcoholism and drug abuse are now copartners with mental health.

PROPOSED PERSONNEL REDUCTION IN 1974

Mr. **Flood.** Dr. Egeberg, the 1974 column of the 1975 budget reflects 1,435 jobs for the Alcohol, Drug Abuse, and Mental Health Administration. That is a reduction of 393 jobs, or 21 percent, from the number proposed to Congress in the 1974 budget. What in the world could possibly justify such a radical reduction in jobs for such important programs, as you insist and everybody else has and does, as alcoholism, drug abuse, and mental health? How do you put that together?

Dr. **Egeberg.** In the first place, that 1,435 figure has after study within the Department and in agreement with what you have just said been raised to 1,631. That has happened within the last 3 weeks.

Mr. **Flood.** That is something.

Dr. **Egeberg.** Yes, that shows that the Department has been concerned about this.

Mr. **Flood.** Am I correct in thinking that the desire to make these staffing reductions has been reversed?

Dr. **Egeberg.** The decision to make such a drastic staffing reduction has certainly been reversed and sources have been found within the Department to take care of that difference.

Mr. **Flood.** Does that mean that the figures that are now in the budget are inoperative?

Dr. **Egeberg.** Yes, sir.

Mr. **Miller.** As I said yesterday, Mr. Chairman, when we were discussing this for NIH, the congressional authorization is high enough that we can absorb this increase. However, it is higher than the number which appears in the 1974 column of the President's budget. If you would like, we will submit a formal revision to you.

CONGRESSIONAL APPROVAL FOR PERSONNEL REDUCTION

Mr. **Flood.** Do you know why congressional approval was not sought in the first place for such a staffing reduction of appalling magnitude?

Dr. **Egeberg.** All I know is that we were extremely concerned over the reduction. I don't understand the rationale for the reduction, however.

Mr. **Flood.** You don't understand the rationale for what?

Dr. **Egeberg.** Why a cut of this magnitude was taken.

Mr. **Flood.** You are the only guy here.

Dr. **Egeberg.** We protested very strongly. Our protests were listened to and action was taken. We are very appreciative of the fact that we h. i this very sizable return of personnel to our ceiling.

Mr. Flood. I can paraphrase this thing but I don't know how apt it is. Did somebody say to you, do you think that the gentleman protests your virtue too much, somebody topside?

Dr. Egeberg. I have used that expression at times, too, sir.

Mr. Flood. Good.

Dr. Egeberg. Part of my personality is trying to explain something as far as I can, and it often becomes a protest.

Mr. Flood. Don't break down and cry. It is a little early.

Has this reduction in force been carried out?

Dr. Egeberg. No. It was to have been accomplished by June 30 of this year; however, with the restoration of positions to our ceiling a reduction in force is no longer necessary.

Mr. Flood. It is a question of timing.

How many employees are currently on the rolls as of quarter of 11 this morning?

Dr. Egeberg. 1,586.

Mr. Flood. What additional amount in dollars will be required for fiscal year 1975 in order to restore the staffing level which was proposed in the 1974 budget? You can provide for the record those figures broken down by activity.

Dr. Egeberg. Yes, sir.

[The information follows:]

1975 FUNDS REQUIRED TO RESTORE 1974 STAFFING LEVELS

The 1975 President's budget was formulated at a time when NIMH fiscal year 1974 employment levels were to be decreased by 194 over those originally planned. Likewise, employment levels for the Office of the Administrator were reduced by 21 positions. This resulted in reduced operating costs for general mental health management and information and program direction in fiscal year 1975. Drug and alcohol management and information activities were unaffected.

With the rescision of these reductions, additional funds are necessarily required in fiscal year 1975. General mental health management and information will require a total of $24,339,000. This will provide mandatory increases such as within-grade increases and pay raise costs, as well as restore direct-operations reductions.

In addition, $10,896,000 will be required to support operating expenses in program direction as a result of the restoration of the positions in 1974.

REVISED 1975 BUDGET PROPOSAL

Mr. Flood. In view of the fact that this reduction in positions has been canceled are you going to submit a revised budget?

Dr. Egeberg. I think we will have to ask Mr. Miller.

Mr. Miller. I think what I said previously applies, Mr. Chairman. We have enough money and enough positions authorized by the Congress to cover this restoration in fiscal year 1974, and of course we still have the 1975 proposal before you on employment, and there is enough money in the budget to cover it.

Mr. Flood. Are you going to change the 1975 proposal?

Mr. Miller. If when the appropriations process is complete—and this is for the whole of HEW—if the congressional authorizations for employment are above those we are proposing and we need to request more funds we will, but we have to look at the whole Department employment situation when the appropriations process is completed. There are enough dollars however in the budget to cover what we are requesting now.

RELEASE OF FISCAL YEAR 1973 APPROPRIATIONS

Mr. FLOOD. The 1974 obligations include $139,882,000 from the 1973 appropriation released from impoundment. Is that right?

Dr. EGEB[illegible]es, sir.

Mr. FLOO[illegible]en for the record can you give us a detailed breakdown of th[illegible]ount, the description of how the funds are going to be used?

Dr. EGEBERG. Yes, sir.

[The information follows:]

Distribution of released funds by budget activity

	1973 impounded funds
General mental health:	
Research:	
Grants	$10,100,000
RCP	1,000,000
HIP's	181,000
Direct operations	----
Subtotal	11,281,000
Training:	
Grants	25,248,000
Fellowships	2,739,000
Subtotal	27,987,000
Community Programs:	
Construction	20,000,000
Staffing	---
Children's services	---
Subtotal	20,000,000
Management and information	---
Total, general mental health	59,268,000
Drug abuse:	
Research	---
Training	---
Community programs:	
Grants and Contracts	---
Formula Grants	---
Subtotal	---
Management and Information	---
Total, drug abuse	---
Alcoholism:	
Research	4,700,000
Training	5,400,000
Community programs:	
Grants and contracts	39,309,000
Formula grants	30,000,000
Subtotal	69,309,000
Management and information	1,205,000
Total, alcoholism	80,614,000
Program direction	---
Total ADAMHA	139,882,000

Listed below is a description of the programs which will be funded with the funds released from the fiscal year 1973 appropriation. The fiscal year 1975 budget was formulated on the assumption that most new alcoholism grants awarded from fiscal year 1973 released funds would be full funded on a multiyear basis. This was done after advice from several sources including the Office of General Counsel. Since that time, the legality of multiyear funding from fiscal year 1973 funds has been questioned by attorneys for the plaintiff in the suit brought against the Department by the National Association of Mental Health and by Members of the Congress for both fiscal year 1973 and fiscal year 1974. We are, therefore, in the process of reformulating our funding strategy so as not to violate the court order.

1. GENERAL MENTAL HEALTH

Research

Research funds released as a result of the court order will be used, for the most part, to fund new and competing renewal high priority projects which were approved by the National Advisory Mental Health Council but remained unfunded in fiscal year 1973. Of the $10,100,000 released for regular research grants, $7,600,000 will be used to support approximately 103 new projects and $1,624,000, for aprpoximately 28 competing renewal projects. The remaining funds will be used to supplement some competing and noncompeting continuations which were considerably reduced in fiscal year 1973. This would restore these projects to funding levels they would have had if the funds were made available in 1973. In addition, approximately six new projects will be supported from the $181,000 released for the research career program (RCP) and $1 million released for the hospital improvement program (HIP) will be used to fund approximately four new projects and six competing renewal projects.

Training

NIMH intends to use the 1973 released funds to fund a small number of new awards in the categorical training disciplines. This includes 45 grants totaling $2,639,000. The remaining funds will be used to restore awards to their approximate award level in 1972. This is necessary since the phaseout policy of categorical training programs, originated in fiscal year 1973, limits awards to an amount necessary for students who had received a commitment for support from the institution and for a proportionate share of institutional costs. The restoration of 1974 training programs will necessitate the obligation of $22,609,000.

The $2,739,000 restored to the fellowship program will be used to fund 442 new awards in the pre-doctoral fellowship program.

Construction

The $20 million released for Community Mental Health Centers will be used to fund 114 new grants to finance the building or renovation of facilities to house community mental health centers.

2. ALCOHOLISM

Research

The $4,700,000 released for "Alcoholism research" will be used to support approximately 57 new grants. Some prgoram areas receiving support are the etiology of alcoholism, alcoholism prevention and education; behavioral and psychological effects of alcohol; and alcohol and the need for or availability of services for alcoholic persons.

Training

The $5,400,000 restored for training grants will be used to fund approximately 30 new training awards. An example of a priority area in which new grants will be awarded is improving and developing curriculums on alcoholism in medical schools in an effort to sensitize students to the needs of alcoholic persons.

Community Programs

Funds released for alcoholism community programs will be obligated in the following manner: $800,000 to fund 2 new staffing grants; $38,509,000 for approximately 83 new community project grants and contracts; and, $30 million to the formula grant programs to States. High priority community project grant programs include the Indian alcohol program, drinking drivers program, and Alaskan Native program.

MULTIYEAR FUNDING

Mr. FLOOD. How much money will be obligated in fiscal 1974 to fund grants for more than 1 year?

Dr. EGEBERG. Our present policy, sir, is under discussion. We were told initially by the Office of General counsel that it was appropriate to fund projects for more than 1 year and our plans were formulated on that basis. But within the last week we have been told that there is now some question about the practice.

Mr. FLOOD. Did somebody know you were coming up here sooner or later?

Dr. EGEBERG. I don't think so.

Mr. FLOOD. It sounds like it. You know I think somebody did.

Dr. EGEBERG. We certainly did, sir.

Mr. FLOOD. I know. We had a copy of your statement longer than that.

Dr. EGEBERG. There has been recent correspondence on this subject from lawyers representing the plaintiffs in the *NAMH* v. *Weinberger, et al*, court suit. More importantly the Congress has questioned this practice and said it was not their intent that there be multiyear funding. If it is not consistent with congressional intent, we don't want to do it. These facts have come up within the last 2 weeks and brought about a decision to discuss the whole issue at our level and at the Secretary's level, and we will have a decision on it, I think, shortly.

Mr. FLOOD. What letters have been written?

Dr. EGEBERG. Senator Magnuson wrote a pretty strong letter saying he did not think this was congressional intent.

Mr. MILLER. Again referring to a previous comment I made at the hearings, there is a distinction to be made in what Dr. Egeberg said between 1973 and 1974 funds. His Institute has the one example in Health, Education, and Welfare where our current plans include multiyear funding of fiscal year 1973 money, and this is under review from a legal standpoint. It is clear, however, that we do have proposals before you to multiyear fund 1974 funds.

Mr. FLOOD. Give us a breakdown of the amount we are talking about by programs, showing the true program level now for the funding in 1974 and 1975.

[The information follows:]

MULTI-YEAR FUNDING

In the 1975 Congressional Justification, ADAMHA proposed to use funds from the FY 1974 appropriation to multi-year fund new General Mental Health training grants. It also proposed to utilize funds restored from the FY 1973 appropriation, as well as 1974 Congressional increases to full-fund new alcoholism research, training, and community project grants and contracts on a multi-year basis. The number of projects and the true program level of funds proposed for multi-year funding are shown below.

(Dollars in thousands)

	1974		1975		1976		Total FY 1974 Awards	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
General Mental Health:								
Training Grants:								
New Proj. 1974...	18	$1,100	18	$900	18	$600	18	$2,600
Alcoholism:								
Res. Grants 1974	29	1,000	29	1,000	29	1,000	29	3,000
1973	31	1,400	31	1,400	31	1,400	31	4,200
Subtotal, Res. Grants..........	60	2,400	60	2,400	60	2,400	60	7,200
Training Grants								
1974............	4	1,569	4	1,568	---	---	4	3,137
1973............	30	1,800	30	1,800	30	1,800	30	5,400
Subtotal, Training	34	3,369	34	3,368	30	1,800	34	8,537
Community Prog:								
Proj. Grants & Contracts 1974:								
New............	12	4,244	12	4,245	12	4,245	12	12,734
Continuations..	232	16,800	232	16,800	---	---	232	33,600
Subtotal.........	244	21,044	244	21,045	12	4,245	244	[illegible]
1973...........	33	12,837	83	12,836	83	12,836	83	38,509
Subtotal, Comm. Prog............	327	33,881	327	33,881	95	17,081	327	84,843
Total, Alcoholism..	421	39,650	421	39,649	185	21,281	421	100,580
Total, ADAMHA......	439	40,750	439	40,549	203	21,881	439	103,180

It should be noted, however, that the FY 1975 budget was formulated on the assumption that most new alcoholism grants awarded from the FY 1973 released funds would be full-funded on a multi-year basis. This was done after advice from several sources including the Office of General Counsel. Since that time, the legality of multi-year funding from FY 1973 funds has been questioned by attorneys for the plaintiff in the court suit brought against the Department by the National Association of Mental Health and by members of the Congress for both FY 1973 and FY 1974. We are, therefore, in the process of reformulating our strategy so as not to violate the Court Order.

REFLECTION OF BUDGET IN PROGRAM LEVEL TERMS

Mr. FLOOD. Any way you look at this thing, to be frank, your 1975 budget looks pretty bad. Depending upon which figures you use, and you can take your choice, it is a reduction of either $129 million or $269 million. However, we do not think that the budget justification reflects a valid comparison there for the 1974 and 1975 budget. Therefore what we want you to do is this: We would like you to adjust all of the tables in that budget justification to reflect, first, the 1973 appropriations that were obligated in 1974, and, two, the true program levels in the 1974 and 1975 budget where the 1974 obligations are being used to fund grants or contracts, either one, for more than 1 year. There is no reason why you can't do that at all.

Dr. EGEBERG. We will give you that for the record.

[The information follows:]

Obligations by Activity

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
General Mental Health						
Research.............	330	$90,146,000 (101,427,000)	330	$84,468,000 (84,468,000)	---	-$5,678,000 (-16,959,000)
Training.............	---	100,034,000 (128,021,000) [126,521,000]	---	65,101,000 (65,101,000) [66,001,000]	---	-34,933,000 (-62,920,000) [-60,520,000]
Community Programs:						
Construction of Centers...........	---	14,250,000 (34,250,000)	---	--- (---)	---	-14,250,000 (-34,250,000)
Staffing of Centers	---	155,513,000	---	172,053,000	---	+16,540,000
Mental Health of Children..........	---	19,000,000	---	26,844,000	---	+7,844,000
Management & Infor. .	383	23,163,000	373	16,753,000	-10	-6,410,000
Subtotal...........	713	402,106,000 (461,374,000) [459,874,000]	703	365,219,000 (365,219,000) [366,119,000]	-10	-36,887,000 (-96,155,000) [-93,755,000]
Drug Abuse						
Research.............	108	34,056,000	108	34,000,000	---	-56,000
Training.............	---	15,138,000	---	9,969,000	---	-5,169,000
Community Programs:						
Project grants & contracts..........	---	182,649,000	---	122,000,000	---	-60,649,000
Grants to States....	---	25,000,000	---	35,000,000	---	+10,000,000
Management & Infor...	227	15,571,000	298	15,646,000	+71	+75,000
Subtotal...........	335	272,414,000	406	216,615,000	+71	-55,799,000

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Alcoholism:						
Research.............	6	8,489,000 (13,189,000) [8,389,000]	6	10,405,000 (10,405,000) [12,805,000]	---	+1,916,000 (-2,784,000) [+4,416,000]
Training.............	---	6,824,000 (12,224,000) [7,056,000]	---	1,947,000 (1,947,000) [5,315,000]	---	-4,877,000 (-10,277,000) [-1,741,000]
Community Programs: Project grants & contracts.........	---	66,956,000 (106,265,000) [55,303,000]	---	32,051,000 (32,051,000) [65,932,000]	---	-34,905,000 (-74,214,000) [+10,629,000]
Grants to States.....	---	45,600,000 (75,600,000)	---	45,600,000 (45,600,000)	---	--- (-30,000,000)
Management & Infor...	91	10,040,000 (11,245,000)	107	9,863,000 (9,863,000)	+16	-177,000 (-1,382,000)
Subtotal...........	97	137,909,000 (218,523,000) [157,593,000]	113	99,866,000 (99,866,000) [139,515,000]	+16	-38,043,000 (-118,657,000) [-18,078,000]
Buildings & Facilities	---	---	---	200,000	---	+200,000
Program Direction	290	9,146,000	290	10,462,000	---	+1,316,000
Total Obligations (bases).............	1,435	821,575,000	1,512	692,362,000	+77	-129,213,000
Total Obligations....		(961,457,000)		(692,362,000)		(-269,095,000)
Program Level........		[899,027,000]		[732,911,000]		[-166,116,000]

General Statement Table - P. 19 Congressional Justification
Revised to show true 1974 - 1975 Program Levels
(Amounts in thousands)

	Base	Estimates	Decrease
General Mental Health.....	$459,874	$366,119	-$93,755
Drug Abuse................	272,414	216,615	-55,799
Alcoholism................	157,593	139,515	-18,078
Buildings & Facilities....	---	200	+200
Program Direction.........	9,146	10,462	+1,316
Total.....................	899,027	732,911	-166,116

OBLIGATIONS BY BUDGET ACTIVITY
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET PROGRAM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
General Mental Health:								
Research:								
Research Grants........	1,182	$64,568	1,098	$57,802	1,179	$71,272	877	$56,812
Hospital Improvement Projects..............	73	6,751	73	5,900	153	6,900	49	4,900
Research Career Program	172	5,045	144	4,390	159	4,647	107	3,201
Total Program Level, Research Grants...........	1,427	76,364	1,315	68,092	1,491	82,819	1,033	64,913

OBLIGATIONS BY BUDGET ACTIVITY
SHOWING "TRUE" PROGRAM LEVELS
IN 1973 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET PROGRAM	1973 AMOUNT	1974 AMOUNT	1975 AMOUNT
General Mental Health:			
Research Grants:			
Behavioral sciences....	$17,869	$20,221	$17,290
Clinical research......	8,434	10,261	8,900
Applied research.......	5,617	5,442	4,180
Psychopharmacology.....	10,455	13,065	11,300
Epidemiology...........	1,697	2,067	1,672
Services development...	7,097	9,771	7,125
Crime and delinquency..	2,913	4,938	3,045
Metropolitan problems..	1,674	2,368	1,400
Minority mental health	2,046	3,139	1,900
Total Program Level, Research Grants....................	57,802	71,272	56,812

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(Amounts in Thousands)

	1972		1973		1974		1975	
BUDGET MECHANISM	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
Hospital Improvement Program: Continuations............	43	$3,905	54	$4,202	43	$4,158	49	$4,900
Competing renewals........	11	1,061	8	758	15	1,485	---	---
New projects.............	19	1,785	11	940	13	1,257	---	---
Total, Program level, HIP Grants................	73	6,751	73	5,900	71	6,900	49	4,900

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

	1972		1973		1974		1975	
BUDGET MECHANISM	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
General Mental Health:								
Research Grants:								
Continuation................	596	$38,846	670	$36,100	558	$36,337	645	$49,412
Competing renewals..........	118	9,238	102	6,849	169	9,747	107	5,650
New projects................	468	13,603	201	10,857	302	22,312	---	---
Small grants................	187	1,174	125	3,192	150	1,000	125	750
Supplementals...............	(102)	1,707	(137)	804	(73)	1,876	(39)	1,000
Total Program Level, Research Grants........................	1,369	64,558	1,098	57,802	1,179	71,272	877	56,812

OBLIGATIONS BY BUDGET ACTIVITY
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET PROGRAM	1972 AMOUNT	1973 AMOUNT	1974 AMOUNT	1975 AMOUNT
Research Career Program:				
Research scientist development	$2,627	$2,152	$1,710	$960
Research scientist..............	1,878	1,751	2,492	1,851
Research career...............	540	487	445	390
Total Program Level, Research Career Program................	5,045	4,390	4,647	3,201

OBLIGATIONS BY BUDGET ACTIVITY
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET PROGRAM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
General Mental Health:								
Training:								
Training Grants..........	1,838	$101,346	1,304	$73,954	1,964	$117,896	1,063	$60,401
Hospital Staff Develop...	152	3,614	114	2,574	96	2,400	64	1,600
Fellowships.............	433	3,498	95	821	617	6,225	547	4,000
Total Program Level, GMH Training....................	2,423	108,458	1,513	77,349	2,677	126,521	1,674	66,001

Obligations by Budget Activity
Showing "True" Program Levels
in 1972 - 1975
(Amounts in thousands)

Budget Program	1972 Amount	1973 Amount	1974 Amount	1975 Amount
General Mental Health				
Training:				
Experimental and special..........	$10,010	$9,948	$13,749	$4,487
New careers.......................	1,168	1,451	499	70
Continuing Education............	4,266	4,342	2,046	105
Psychiatry 1/......................	35,942	21,150	43,511	21,131
Epidemiology......................	331	331	331	239
Psychiatric nursing...............	10,549	6,011	12,234	5,990
Social Work.......................	13,318	8,939	17,036	9,285
Behavioral Science................	25,762	21,782	28,490	19,094
Total, Program Level, GMH Training Grants.....................	101,346	73,954	117,896	60,401

1/ Includes General Practioner Training Program

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
General Mental Health:								
Training Grants:								
Continuation.......	1,515	$80,587	1,206	$65,552	751	$43,092	1,063	$60,401
Competing renewals.	136	8,338	30	1,736	1,088	55,065	---	---
New projects.......	187	11,651	68	1,825	125	7,551	---	---
Supplementals......	(45)	770	(89)	4,841	(1,508)	12,188	---	---
Total, Program Level, GMH Training Grants...	1,838	101,346	1,304	73,954	1,964	117,896	1,063	60,401

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
General Mental Health:								
Fellowships:								
Continuations............	163	$2,120	73	$379	34	$230	442	$2,739
Competing Renewals.........	51	336	17	146	---	---	---	---
New awards.................	219	190	5	94	583	5,995	105	1,261
Supplementals..............	(59)	852	(67)	202	(---)	---	---	---
Total Program Level, GMH Fellowships..................	433	3,498	95	821	617	6,225	547	4,000

OBLIGATIONS BY BUDGET ACTIVITY
SHOWING "TRUE" PROGRAM LEVELS
IN 1973 - 1975
(Amounts in thousands)

BUDGET PROGRAM	1973 AMOUNT	1974 AMOUNT	1975 AMOUNT
General Mental Health:			
Fellowships:			
Predoctoral..............	$615	$2,969	$2,739
Postdoctoral..............	112	2,475	880
Special..................	94	781	381
Total, Program Level, GMH Fellowships..................	821	6,225	4,000

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
Community Mental Health Centers Program:								
Construction................	10	$586	99	$13,611	194	$34,250	---	---
Staffing:								
Continuation..............	338	88,766	456	124,637	456	125,250	513	$172,053
New projects..............	118	46,318	90	40,463	55	30,263	---	---
Subtotal..................	456	135,084	546	165,100	511	155,513	513	172,053
Child Mental Health:								
Continuation..............	---	---	55	8,350	60	8,448	139	26,844
New projects..............	60	9,935	32	11,650	37	10,552	---	---
Subtotal..................	60	9,935	87	20,000	97	19,000	139	26,844
Total Program level, CMHC Program......................	526	145,605	732	198,711	802	208,763	652	198,897

DRUG ABUSE

BUDGET AUTHORITY AND OBLIGATIONS

	1974 Base	1975 Estimate	Increase or Decrease
Project Grants & Contracts	$182,649,000	$122,000,000	$-60,649,000
(BA)......................	(160,770,000)		(-38,770,000)
Formula Grants............	25,000,000	35,000,000	+10,000,000
(BA)......................	(15,000,000)		(+20,000,000)
Total.....................	207,649,000	157,000,000	-50,649,000
(BA)......................	(175,770,000)		(-18,770,000)

BUDGET AUTHORITY AND OBLIGATIONS

	1974 Base		1975 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
CMHC Act:						
Staffing - Sec. 251:						
Continuation..........	24	$13,405,000	24	$14,374,000	---	$+969,000
Demonstration - Sec. 252:						
Continuation..........	7	3,026,000	---	--- 2/	-7	-3,026,000
Service - Sec. 256:						
Continuation..........	101	66,945,000	---	--- 2/	-101	-66,945,000
(BA)................		(49,883,000)				(-49,883,000)
Education - Sec. 253:						
Continuation..........	13	1,700,000	---	--- 2/	-13	-1,700,000
Total, CMHC Act...........	145	85,076,000	24	14,374,000	-121	-70,702,000
(BA).....................		(68,014,000)				(-53,640,000)
DAOT Act:						
Special Project Grants & Contracts - Sec. 410:						
New....................	76	19,707,000	9	4,540,000	-67	-15,167,000
(BA)................		(15,263,000)				(-10,723,000)
Continuation..........	156	75,993,000	276	101,286,000	+120	+25,293,000
Subtotal............	232	95,700,000	285	105,826,000	+53	+10,126,000
(BA)..............		(91,256,000)				(+14,570,000)
Formula Grants - Sec. 409:	56	25,000,000	56	35,000,000	---	+10,000,000
(BA).................		(15,000,000)				(+20,000,000
Total, DAOT Act...........	288	120,770,000	341	140,826,000	+53	+20,126,000
(BA).....................		(106,256,000)				(+34,570,000)
NARA Act - Sec. 607:						
NARA Contracts..........	38	1,500,000	30	1,200,000	-8	-300,000
PHS Act - Sec. 301/513:						
Evaluation..............	---	373,000	---	---	---	-373,000
(BA).................		(---)				(---)
Patient Care Contract....	---	---	1	600,000	+1	+600,000
Total PHS Act............	---	373,000	1	600,000	+1	+227,000
(BA).....................		(---)				(+600,000)
Total Obligations..........	471	207,649,000 1/	396	157,000,000	-75	-50,649,000
(Total BA)..............		(175,770,000)				(-18,770,000)

1/ Includes $31,879,000 funds carried forward from 1973 appropriation.

2/ Continuation funding provided under Section 410 of the DAOT Act in FY 1975.

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
Alcoholism:								
Research......................	127	$8,087	105	$6,939	163	$8,389	262	$12,805
Training......................	54	4,698	59	4,979	80	7,056	59	5,315
Community Programs...........	298	64,744	320	54,855	800	130,903	569	111,532
Management and Information....	---	9,916	---	9,541	---	11,245	---	9,863
Total, Program Level, Alcoholism	479	87,445	484	76,314	1,043	157,593	890	139,515

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
Alcohol Research:								
Grants and Contracts:								
Continuations...............	62	$4,369	84	$4,724	64	$3,718	130	$6,706
Competing Renewals..........	14	1,122	5	555	5	962	3	769
New Projects................	51	2,020	7	194	94	3,186	120	3,098
Supplementals...............	(5)	132	(4)	117	(1)	57	(1)	57
Subtotal.................	127	7,643	96	5,590	163	7,923	253	10,630
Contracts..................	---	---	9	900	---	---	9	1,700
Total, Program Level, Research Grants and Contracts..........	127	7,643	105	6,490	163	7,923	262	12,330

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO.	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
Alcohol Training:								
Grants:								
Continuations............	19	$1,920	42	$4,220	36	$3,458	59	$5,315
Competing Renewals.......	2	112	5	113	10	229	---	---
New Projects.............	33	2,641	12	92	34	3,369	---	---
Supplementals............	(3)	25	(5)	554	(---)	---	(---)	---
Total Program Level, Alcohol Training...	54	4,698	59	4,979	80	7,056	59	5,315

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

BUDGET MECHANISM	1972 NO	1972 AMOUNT	1973 NO.	1973 AMOUNT	1974 NO.	1974 AMOUNT	1975 NO.	1975 AMOUNT
Alcohol Community Programs:								
Project grants and contracts...	242	$34,744	264	$24,855	688	$55,303	538	$65,932
Formula grants..	56	30,000	56	30,000	112	75,600	56	45,600
Total, Program Level, Alcohol Community Programs.............	298	64,744	320	54,855	800	130,903	594	111,532

OBLIGATIONS BY BUDGET MECHANISM
SHOWING "TRUE" PROGRAM LEVELS
IN 1972 - 1975
(AMOUNTS IN THOUSANDS)

	1972		1973		1974		1975	
BUDGET MECHANISM	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
Alcohol Community Programs:								
Project Grants and Contracts:								
Staffing grants:								
Continuations..............	27	$7,494	31	$7,746	45	$10,051	45	$11,051
New.........................	14	4,198	---	---	2	800	---	---
Subtotal, Staffing grants.	41	11,692	31	7,746	47	10,851	45	11,051
Grants and Contracts:								
Continuations..............	---	---	233	16,410	386	24,871	421	39,881
New.........................	201	27,652	---	699	255	19,581	47	15,000
Subtotal, Grants and Contracts...........	201	27,652	233	17,109	641	44,452	468	54,881
Total Program Level, Project Grants and Contracts...........	242	39,344	264	24,855	688	55,303	513	65,932

INCIDENCE OF MENTAL ILLNESS

Mr. Flood. Last year we were told that about 20 million people were afflicted with mental illness in the United States. Is that still a good figure?

Dr. Egeberg. Yes. There are probably a little more but it is a rough estimate.

Mr. Flood. Will you put in the record a summary of what you think are the important statistics on mental illness incidence, admissions to mental hospitals, the number of people treated and so on, with the appropriate historical comparison?

Dr. Egeberg. Going back a decade or something like that?

Mr. Flood. Use your judgment.

Dr. Egeberg. Yes, sir.

[The information follows:]

Scope of the National Mental Health Problem

INTRODUCTION

Precision assessment of the national mental health problem is difficult if not impossible, since reliable statistics on the incidence and prevalence of mental disorders in the United States, or any other country, do not exist. One factor contributing to the situation is the absence of reliable diagnostic criteria for most mental disorders. The American Psychiatric Association now recognizes 148 such disorders, grouped into 10 major categories. In numerous cases, however, there is no uniformly accepted definition of the condition. This is true not only for the psychoneurosis, which afflicts more Americans than any other category of mental illness, but for the major psychoses—schizophrenia and depressive disorders—as well.

GROSS ESTIMATES

In spite of the obstacles noted above, figures have been assembled recently which, though not defining the dimensions of the problem with precision, are probably the best available estimates of the numbers of people directly affected. It is likely that in nearly every category the numbers cited are underestimates, since many troubled people never come to the attention of record-keeping agencies. The assembled estimates indicate that no less than 10 percent of the United States population—or 20 million people in 1971—suffer from some form of mental illness. About one-seventh of those afflicted actually receive psychiatric care of some sort.

Based upon those figures—and taking into account such factors as the mentally ill individual's loss of earnings and the cost of care both in and out of institutions—the estimated annual cost of mental illness in this country is about $21 billion, or almost one quarter of the national defense budget. This estimate may well be low; other estimates put the economic costs of alcoholism, alone, at $15 billion annually, and the annual cost of drug abuse at $10 billion. The data below indicate how the overall statistics are distributed among the major categories of mental health problems. In 1971 the admissions to all psychiatric inpatient and outpatient services were at the rate of 1,238.5 per 100,000 people. The admissions were composed of the following diagnostic categories:

Schizophrenia	258.0
Depressive disorders	216.9
Alcoholism	127.9
Organic brain syndromes	54.9
Drug abuse	43.1
Mental retardation	28.9
Other psychotic disorders	18.9
Undiagnosed	88.9
All other diagnoses	401.1

For a better understanding of the scope of mental illness and behavior disorders, consider a hypothetical community of 150,000 citizens—about the middle of the range of the communities in which NIMH-supported community mental health centers have been established. Assume that the hypothetical community directly reflects the characteristics of the population as a whole. Then the following will be true:

> Of the 3,000 children born in the community annually, at least 600 will need some form of mental health service during their lifetime, and 240 will be treated in mental hospitals.
>
> Each year, over 2,000 serious crimes will be committed, an average of 6 crimes a day. The crimes will include 8 murders, 17 forcible rapes, 160 assaults, 376 auto thefts, and 908 burglaries. Some undetected or unreported, and thus uncounted, crimes will be committed in each category. Community juvenile courts will see almost 1,000 youths per year between the ages of 10 and 17 years.
>
> Almost 800 citizens will be admitted to inpatient psychiatric facilities every year.
>
> Resident in the community at any given time will be 600 schizophrenics, tens of thousands of people suffering from varying degrees of depression of different kinds, almost 4,000 alcoholics, 50 narcotic addicts, and 400 mentally ill children, almost one quarter of them in a mental hospital.

As sobering as this picture may be, it represents but the tip of the iceberg. Although mental illness and behavior disorders are not among the leading "killer diseases"—such as heart disease, cancer, and stroke—mental disorders do rank among the top causes of illness, human suffering, and economic loss. When all the ramifications of these disorders are considered, mental illness emerges as the No. 1 health problem in the United States today.

THE MAJOR PSYCHOSES: SCHIZOPHRENIA AND DEPRESSION

Probably in no other aspect of the mental health problem is the lack of standardized definitions more frustrating than in the major functional psychoses. Among its other troublesome consequences, this deficiency has led to many puzzling discrepancies in mental health statistics reported by different nations. Differing British and American views of depression and of schizophrenia are good examples. In a recent study, New York and British psychiatrists were shown identical television recordings of diagnostic interviews with depressed patients. The New York psychiatrists tended to diagnose patients as schizophrenic if they showed some disorganization of thought, whether or not they also showed marked mood disturbances. The British psychiatrists, on the other hand, gave greater weight to affective disturbances and diagnosed those same patients as suffering from mania or depression. Oddly, there are even differences in diagnostic criteria within the United States. Western psychiatrists tended to be more like their British colleagues in diagnostic tendencies than New York psychiatrists; perhaps appropriately, Canadian psychiatrists appeared to be about halfway between the New York and the British-Western United States extremes.

Imprecise diagnosis can seriously interfere with efforts to obtain reliable estimates of the prevalence and incidence of these grave mental disorders. Moreover, with the advent of increasingly sophisticated pharmacotherapies, the need for more precise diagnostic criteria are increasingly important for the judicious clinical use of drugs.

Schizophrenia

Recently the World Health Organization reported the results of a nine-country survey of schizophrenia which indicated that the condition is universal: the core symptoms occur in patients whether they are diagnosed in Denmark or in Nigeria.

Not only does schizophrenia appear to be universal, but it overall incidence seems to average out to around 2 percent of the population, the world over. Interpretations of recent data collected by NIMH are evene more sobering: about 1 in every 20 American children who live beyond the age of 15 years will develop schizophrenia sometime in their lives. The disease strikes its victims preponderantly between the ages of 15 and 44 years. This means that the severe debilitation often caused by schizophrenia is greatest during the most productive years of life.

Schizophrenia may account for as much as one-quarter of all the mental illness that comes to medical attention in this country today. In hard figures, there were 474,000—nearly one-half million—schizophrenic patients admitted to all types of facilities in 1969, the most recent year for which such figures are available. At least half of those patients were suffering a recurrence of the disease. The tendency of schizophrenia to recur is one of its most insidous and frustrating aspects.

The Depressive Disorders

These conditions are probably the most common mental disorders experienced by Americans today. They may also be the most underdiagnosed and unrecognized of all mental ailments. It is estimated that between 3 and 8 million persons in this country suffer from depression at any given time. About 15 percent of all adult Americans between the ages of 18 and 74 years have sufficiently significant symptoms to attract clinical attention and treatment. Based upon these figures, the affective—or depressive—disorders are estimated to cost the Nation between $1.3 and $4 billion annually. The total impact of depression may be greater than indicated because this group of illness appears to be an important factor in triggering many physical ills and in affecting their course. Among the conditions found to be associated with depression are gastrointestinal, neurological, and respiratory diseases. And there is evidence that depression bears adversely on the critical problem of recovery from a heart attack.

Unlike schizophrenia, which may be less prevalent but is much more difficult to treat, depression and manic-depression can be treated effectively with electroshock, antidepressant drugs, and lithium carbonate (for manic depression). Together, these therapies are useful in approximately 80 percent of cases of depressive psychoses.

Nevertheless, diagnostic and treatment issues remain—for example, the problem of distinguishing accurately among different types of clinical depression and between normal and clinical depression.

PSYCHONEUROSES

The psychoneurotic disorders are even more difficult to diagnose and classify than are the psychoses. For this reason, among others, reliable estimates of prevalence and incidence are impossible to obtain. Nevertheless, it is safe to say that neuroses are more prevalent than any other psychiatric disorder, and they are more costly to society than the more serious functional psychoses in terms of suicide, disability, family disruption, marital discord, loss of productivity, and waste of talent and skill.

Most victims of these conditions never burden hospital facilities but either obtain treatment of various sorts privately or simply suffer without professional care. Less than 10 percent of all hospitalized psychiatric patients are classified as psychoneurotic; the true prevalence of the psychoneuroses is certainly far greater than the figure would indicate.

Symptoms of neurotic illness include some forms of depression, anxiety, unreasonable panic, severe and often debilitating phobias, psychosomatic illness, obsessive-compulsive behavior, hysteria, and sexual impediments such as impotence and frigidity. These and other common maladaptive or malfunctional symptoms are so prevalent that it seems unlikely that anyone ever escapes psychoneurosis in one form or another at some time in life.

ORGANIC PSYCHOSIS

Half the mental hospital beds not filled with schizophrenic patients—or about one-quarter of the total mental hospital beds in the Nation—are occupied by patients suffering organic psychosis.

Among the diverse disorders classified under this heading are such impairments of brain function as presenile and senile dementia, toxic drug effects, alcoholic psychosis, sequelae of certain infections, vascular disease, neoplasms, traumas, degenerative disease, endocrine or nutritional disorders, and immune diseases. Some forms of organic psychosis are chronic; others are acute and may be reversible or subject to spontaneous remission.

The senilities are probably the largest category of these mental disorders, affecting an estimated one million Americans in a certifiable way. Senile dementia alone, for example, accounts for roughly 15 percent of all mental hospital admissions in New York State. Most senile patients live in nursing homes or with their own families, partly because there are no effective organic therapies for these psychoses.

Suicide

For more than two decades, suicide has ranked as the 10th leading cause of death among persons of all age groups. Throughout that time, the highest rate of suicide occurred in the 65-years-and-over age group, the maximum rate occurring in white males between 75 and 84 years.

In recent years, however, shifts in the suicide rate have been developing, with more and more of the young taking their lives. Today, suicide is the fourth leading cause of death in the age group of 15 through 44 years; it increased 90 percent from 1955 to 1969 to become the second biggest killer of American college students. During that same period the suicide rate among members of minority groups jumped 32 percent.

Causative conditions in the more than 20,000 recorded suicides annually in this country (the true figure must be much higher) are not easy to determine, but certainly both schizophrenia and the depressive disorders must contribute substantially to the toll, as must the psychoneuroses. (It is safe to say, also, that a significant percentage of homicides—particularly of multiple or mass murders—are precipitated by schizophrenia and depression.)

As many as one-third of all recorded suicides, or 7,300 annually, are estimated to be related in some way to alcohol abuse. Among drug abusers, suicide has become the sixth leading cause of death. And the suicide rate has been climbing recently in the category of crime and delinquency as more and more inmates of jails and prisons manage to destroy themselves. The root causes of these suicides probably include psychoses, psychoneuroses, alcohol, and drugs. Thus, suicide may be seen to be a cross-cutting mental health problem, related to most of the categories of mental illness discussed in this chapter.

MENTAL HEALTH PROBLEMS OF SPECIAL POPULATIONS

Children

Of the 71 million children in this country, 8.5 million—more than one-tenth—are victims of mental health problems. Moreover, that number—and percentage—is expected to grow as it has been growing for the past decade or more. While the number of adult patients in State and county mental institutions has been declining steadily over the past 15 years, both the first admission rates and the resident population rates of children have been increasing at an accelerating pace.

These trends take on added significance when it is considered that more than one-half of the population of this country is now under 25 years old.

Currently, more than 600,000 children are receiving care in a variety of mental health facilities. This means that millions of children are in need of help and are not receiving it. The most severe need for psychiatric services is among children under 15 years old, and the next greatest unmet need is in the age group from 15 to 24 years.

The mental and emotional well-being of the Nation's children and youth are reflected also in crime and delinquency statistics. For example, almost half of all persons arrested in this country for serious crimes—homicide, robbery, and burglary—are under 18 years old, and nearly one-quarter are under 15. Moreover, the problem is worsening, as indicated by the 107 percent increase in the arrest of juveniles for serious crimes between 1960 and 1971.

Criminal or delinquent behavior is as complex in its origin as it is in its expression. Undoubtedly, however, a large proportion of such behavior is the result of mental illness and requires professional treatment rather than imprisonment and punishment. It has been estimated that only about 5 percent of the entire prison population are there legitimately as incorrigibles, belonging to a criminal subculture. An estimated 80 percent are there for the first time, never to return, and are not strictly classifiable as criminal types; they are better described, largely as victims of error, usually of their own. The appropriateness of penal incarceration for this group is an open question. The remaining 15 percent of the prison population are believed to be improperly imprisoned, since they are mentally ill and require treatment, not imprisonment.

The difficulty, of course, is partly in sorting out the three populations from one another and treating them accordingly. The matter of identifying the mentally ill criminals and delinquents so that they can be afforded proper treatment is a major challenge to the mental health field.

Minority groups

Among minority groups with special mental health problems are the Black Americans, Spanish-speaking Americans, Asian Americans, and American Indians. Unique problems in each of these groups create special needs in the mental health field. None of the groups is having its mental health needs met adequately, partly because the orientation of the Nation's mental health practices do not always mesh with minority group perspectives, life styles, and value systems.

The poor

The minority group perhaps most in need of mental health assistance is the poor, who, as a group, suffer the highest rate of mental disorders and so contribute significantly and disproportionately to the Nation's mental health problem. This is evident from the fact that hospitalization rates for mental illness rise significantly in areas where there is a marked confluence of unemployment, undereducation, substandard housing, discrimination, and other social ills.

The poor not only suffer disproportionately from the most serious, costly, and long-lasting mental disorder—schizophrenia—but are also afflicted in disproportion to their number with alcoholism, delinquency, and drug abuse. The costs to the Nation are also disproportionately great; patients from this population have longer hospital terms, lower discharge rates, and poorer chances for successful adjustment after hospitalization.

The aged

Persons over 65 now comprise 10 percent of the country's population but account for 17 percent of all first admissions to mental facilities and for 30 percent of the resident population of those facilities. It is estimated that about 5 percent of this group are institutionalized; that 50 percent of the aged who are in nonpsychiatric institutions have significant mental disability; and that as many as 3 million of the noninstitutionalized aged persons suffer moderate to severe psychiatric problems. Further, it is estimated that one-quarter of the elderly patients in State mental hospitals could be placed more appropriately in other protective settings. Obviously, the elderly people in this country are not receiving psychiatric and other health services in accordance with their needs.

TERMINATION OF FEDERAL SUPPORT FOR CMHC'S

Mr. FLOOD. I do not propose now to carry on a long discussion with you about the termination of Federal support for the new community mental health centers. I went through all of this as you know with Dr. Brown last year. However, I would like to ask you this: What evidence is there to indicate that States and local communities will continue to support community mental health centers after the Federal support is phased out?

Dr. EGEBERG. For one thing the degree of support they give right now. Did you know, sir, that approximately 70 percent of the support of community mental health centers comes from non-Federal funds. On the average we are just supplying 30 percent of it.

There has been an increasing interest in the success of these community mental health centers since they allow the States to close out their large mental institutions. The people at the State level and certainly at the community level have been very, very much interested.

One other factor is that traditionally the States have the responsibility for mental health care. This together with the fact that over 600 community mental health centers have been funded by NIMH and over 530 will be in operation by June 30, 1975, it is felt that responsibility can now be turned over to the States.

Mr. FLOOD. Isn't it true that most health insurance policies do not pay for treatment in community mental health centers?

Dr. EGEBERG. We are working on that.

Mr. FLOOD. Isn't that true?

Dr. EGEBERG. It has been true——

Mr. FLOOD. Isn't it true?

Dr. EGEBERG. That most of them don't? Yes, sir.

Mr. Flood. Now what? Do you want to add something to that?

Dr. Egeberg. Yes. We are working on trying to change those things, but the first thing we have to do to change those policies is to establish criteria——

Mr. Flood. To change the policy or to change the criteria?

Dr. Egeberg. To change the policies. We are working on insuring that mental illness is included in the administration's proposal for a comprehensive health insurance program.

Mr. Flood. How many community mental health centers have been started without any Federal assistance at all?

Dr. Egeberg. About 75. When I was in California we began to start them before the Federal Government did.

Mr. Flood. Even if health insurance pays for services in the community mental health centers where will the money come from for startup costs?

Dr. Egeberg. From the States.

Mr. Flood. What?

Dr. Egeberg. From the States and the counties.

GOAL OF NATIONWIDE COVERAGE BY CMHC'S

Mr. Flood. Is the goal for 1,500 or 1,600 whatever the figure is community mental health centers still a desirable one?

Dr. Egeberg. As you probably know better than I, a group evaluated the population distribution of this country and established what they felt were service areas with roughly 200,000 people to each one. On that basis they felt there should be around 1,500 or 1,600 areas in order to cover the country.

I don't know that I could make a positive statement at this time on what is needed. I would probably like to see as many as possible, because I think this is, as you said, sir, or as Mr. Smith said, one of our desperately important problems.

Mr. Flood. What is?

Dr. Egeberg. Mental health, the whole field of mental health.

Mr. Flood. That is good.

For the record again will you provide a statement giving all of the good arguments that you can think of, that is quite an invitation, it better be good—for terminating Federal assistance for new community mental health centers. Isn't that nice that I ask you to do that for the record instead of making a murder case here?

Dr. Egeberg. Yes, sir.

Mr. Flood. Are you surprised?

Dr. Egeberg. You notice both of these gentlemen are taking notes on this.

[The information follows:]

Phaseout of Federal Assistance for New CMHC's

The value and effectiveness of innovative community mental health centers offering community-based delivery of mental health care has been amply demonstrated. These centers can and will continue to play a very important role in the management of mental and emotional illness. However, it is the philosophy that the provision of mental health services is a shared responsibility, requiring inputs and efforts not only from the Federal Government but also from States, localities, and private organizations, agencies, and institutions. It is now time to shift the responsibility for developing and operating such facilities to State and local agencies which must ultimately bear the major responsibility for the direct provision of public health services of all kinds. This shift reflects the intent of the community mental health centers legislation that eventually every center will be financed by resources other than Federal construction and staffing grants.

Sources of community mental health center funds are varied. They include State government funds, received through the regular appropriations process and also from general revenue sharing, and local governmental financing, provided by city, township, and county appropriations. Also on the local scene are fundraising and other efforts. An additional source of financial support is the utilization of third-party payments, including Federal medicare and medicaid support as well as private health insurance. With the incipient advent of a national health insurance program with the Federal Government assuming responsibility of assuring consumer purchasing power for mental health as well as other health services, the community mental health centers will be able to draw upon this additional source of support.

Certain other sources must also be added such as patient fees and foundation support. An analysis of the most current data indicates that funds for the support of community mental health centers provided by Federal staffing grants accounted for 31 percent of center revenues. Another way of expressing this statistic is that 69 percent of funds were provided by other sources. These figures do not include general revenue-sharing funds dedicated to mental health improvements, because the authority for that program, the State and Local Fiscal Assistance Act of 1972, did not provide funds until January 1, 1972. Moreover, with respect to an additional aspect in insuring the fiscal stability of any center—its ability to maximize its utilization of medicare, medicaid, and other third-party health insurance programs—the amount of third-party payments received has been increasing dramatically. In sum, data indicate that the community mental health centers program has proven itself and should now be absorbed by the regular health service delivery system. The States should be willing and able to assume the planning responsibility for carrying the program forward.

Finally while the Federal Government does not intend to fund new centers after June 30 of this year the community mental health centers program is not being terminated. The intention is to honor continuation commitments to existing centers for the duration of their present 8 years of grant support. Moreover, although the Federal Government will not be involved in the direct financial support of additional community mental health centers, continuing contributions in technical assistance, consultation, and resources development will be made.

REDUCTION IN NIMH RESEARCH BUDGET

Mr. Flood. Can you explain why the budget—I have to ask you because you are the witness. Can you explain why the budget proposes to fund no new research projects in mental health in fiscal year 1975?

Dr. Egeberg. No, sir, I cannot.

Mr. Flood. I am not surprised.

Dr. Egeberg. I have to think on a philosophical basis that there is somebody else making decisions on a broad scope, and that in their opinion that mental health research was of not adequate priority to get the funding.

Mr. Flood. Philosophy?

Dr. Egeberg. Yes, philosophy.

Mr. Flood. That is a good defense mechanism.

Dr. Egeberg. There is a lot of philosophy in the budget, isn't there?

Mr. Flood. Is there?

Mr. Miller. I have to add a word on that, Mr Chairman.

Mr. Flood. On the philosophy? Mr. Miller on the philosophy.

Mr. Miller. I think that if the philosophy were to fund no new research grants in mental health, it would be incorrect. And we are very actively reviewing it, the Under Secretary personally, to take a look to see if this is not something we need to correct.

However, I do need to point out that there is money in the budget for a number of competing projects. There are two kinds of new starts. We have what are called competing continuations and we also have new projects. There is enough money for over 100 new competing continuations. There is also a substantial increase in our estimates as to what it will take to cover noncompeting continuations. I do think that we may be able to get some new money out of that.

So I fully believe that we will end up with some new projects, and I frankly can find no place in the Federal Establishment where we have a philosophy that says there should be no new research project grants in mental health.

Mr. Flood. Just to show what the situation is, what is the number and the dollar level of approved but unfunded research projects that you anticipate in 1974 and 1975?

Dr. Egeberg. For the record?

Mr. Flood. If you have it, what is it?

Dr. Egeberg. No, I don't have the number. We have a large number of applications.

Mr. Flood. Somebody is nudging your elbow there. What does that look like?

Mr. Leone. We will have to supply it for the record. We don't have it with us, particularly for 1975 since we have yet to receive applications for that year.

[The information follows:]

APPROVED UNFUNDED RESEARCH PROJECTS--NATIONAL INSTITUTE OF MENTAL HEALTH

	Number	Amount
June 30, 1974 estimate	321	$13,350,000
June 30, 1975 estimate	652	[1] 26,700,000

[1] This total does not include the $13,350,000 unfunded from fiscal year 1974.

NIMH EFFORTS ON SENILITY

Mr. Flood. Last year in our report we urged that more emphasis be placed on research on senility. What has been done in response to that statement in our report?

Dr. Egeberg. Most of that work has been in the field of mental health, and I think Dr. Plaut should be able to answer that.

Dr. Plaut. Mr. Chairman, partly stimulated by the inquiries from the legislative branch last year we have made significant investment of over $2 million on new projects in the area of senility, including such varied things as understanding better the mechanism of learning and memory, basic science research, the role of proteins in learning, in an effort to see whether that could not also have some impact eventually on the learning problems which elderly people have.

Second, we have undertaken in several places in the country intensive evaluation of inpatient programs for older persons to examine whether the kinds of social support they have, the kinds of relationships they have with other people may not be sufficiently improved so that some of the senility and symptoms of that kind can be ameliorated and can become less.

Within the research dollars available to us we have also in New York City, for example, undertaken a project to assist those isolated and to do a study of those isolated older persons living in SRO, single room occupancy hotels, to see whether they can be assisted to function more independently and in happier fashion on their own.

Dr. EGEBERG. I have had some personal experience in working with senile individuals. In California we took 100 patients who were considered to be quite senile, with chronic brain syndrome. They lay in their beds most of the time, and almost all of them incontinent. Many of them had to be fed in bed. For the most part, we just gave them warm personal support. We added nurses to the program and they were encouraged to treat the patients with special care. By the end of a year some of the patients who had been considered to have chronic brain syndromes and were not responding to any previous care began living together in apartments outside of the institution. Most of them are able to feed themselves again and they had begun to socialize.

SIGNIFICANT ITEMS IN HOUSE AND SENATE REPORTS

Mr. FLOOD. Doctor, all of the last couple of weeks we have all been here, as you know, or heard, all of NIH. All of their research justifications contain a page or pages on "Significant Items in House and Senate Appropriation Committee Reports."

Yours does not. Would you provide a statement for the record now and be sure to include it in your justifications in future years?

Dr. EGEBERG. I am sorry that wasn't in there.

[The information follows:]

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATIONS COMMITTEE REPORTS

ITEM	ACTION TAKEN OR TO BE TAKEN
1974 House reports:	
General mental health—Research grants:	
Committee expects the National Institute of Mental Health to support the pursuit of new leads in mental health of the elderly and research into the causes of senility.	In recognition of the need for greater understanding of the special mental health problems associated with aging, the NIMH operates a section on aging within the Division of Special Mental Health programs. Among the research projects now underway are basic studies of biological mechanisms of aging; psychiatric illness among the aged; social, psychological and cultural influences relating to adjustment in later life; and applied research demonstrating innovative methods for assisting old persons to maintain optimum functioning. Hospital improvement projects are being used to address problems of the elderly in terms of reduction of length of hospitalization, and restoration of a fully functional status. NIMH is working with SRS and SSA on an interagency community on mental health services, addressing medicare and medicaid programs related to mental health aspects of caring for the aged, and the development of alternative means of care.

Training grants and fellowships: The Committee considers it very unwise to terminate or phaseout all existing programs, without a much more careful analysis of their merits and deficiencies.	The mental health training program will support an estimated 1,209 new-competing training grants and fellowships from funds appropriated in fiscal year 1974.
Child mental health: Committee intends that new moneys in 1974 be made available both for the construction of facilities as well as for the provision of services and training of personnel.	During the current fiscal year, a total of 37 new projects will be awarded for children's services. Although the strongest need is for staffing support, some funds have been earmarked for the construction of child mental health facilities. In the majority of cases, however, child mental health staffing grants are awarded to existing Community Mental Health Centers.
1974 Senate report:	
General mental health: The committee encourages studies on the emotional and psychological problems of youth caused by ethnic and racial misunderstanding.	The Institute operate a Center for Minority Group Mental Health programs for the purpose of increasing the Nation's ability to deal with the special needs of this group through the coordination and support of special programs in services, training, and research. Through its minority center, NIMH also provides consultation in a wide variety of programs; sponsors conferences relating to minority mental health; and participates in the development of a variety of publications relating to its specialized area.
Alcoholism: The committee recommends that up to $2,500,000 of 1974 increases be used to develop and implement a statewide campaign against alcoholism, as it relates to Alaskan Natives.	In 1974, the National Institute on Alcohol Abuse and Alcoholism is making 160 awards totaling $2,500,000. These projects are designed to combat the incidence of alcoholism among the Alaskan natives, including the development of special educational material designed by Alaskan Natives to address the unique alcohol problems that exist among this population.
Mental health efforts on behalf of Vietnam veterans: The committee encourages continued emphasis on research and service programs which focus on the long-term needs and problems of veterans and their families.	The Institute is continuing collaborative efforts with the Veterans' Administration and the U.S. Navy Center for the study of prisoners of war. The Institute is working with the veterans group to promote research into what is generally known as the "Post-Vietnam Syndrome." In the service area, several community mental health centers have developed special therapy programs for returning veterans and their families, including veterans with drug problems.

MANDATORY INCREASE IN NIH MANAGEMENT FUND

Mr. Flood. Please explain the increase of $666,000 for extramural research. On page 19 of your justification.

Dr. Egeberg. I think that is mostly salary increases, mandatory items.

Mr. Flood. Take a look at page 19 of your justifications. The point is what I refer to does not mention salaries, it says "Other Objects, $666,000."

Dr. Egeberg. That then is money we pay the National Institutes of Health for supplies and services received by our intramural research program in space which we occupy at the National Institutes of Health.

Mr. Flood. $666,000.

Dr. Egeberg. We have quite a few laboratories at the NIH campus.

EVALUATION OF NIMH TRAINING PROGRAM

Mr. Flood. Last year we were told that an evaluation of the NIMH training program was underway. Has the evaluation been completed?

Dr. Egeberg. I know that one 27,000-page book is out.

Mr. Flood. Has the evaluation been completed?

Dr. Plaut. No, sir. We have only a very preliminary set of findings at this point.

Mr. Flood. It has not If and when it is, before the record goes to print, will you put a summary of it in the record?

Dr. Plaut. We will be glad to, Mr. Chairman.

[The information follows:]

Condensed Preliminary Reports Followup Survey of NIMH-Supported Trainees, 1948–68

The overriding goal of all NIMH training programs since 1948 has been to increase the number and improve the quality of mental health workers. The mechanism employed has been grants to training institutions to enable them to upgrade their programs, employ additional teaching staff, and provide stipends to their students. It was hoped that these students would then go on to be leaders in their fields, conducting research, teaching, supervising and becoming mental health administrators as well as providing needed clinical services. In an attempt to determine whether or not this indeed was the case, a study was conducted in-house by staff who administer the Institutes Division of Manpower and Training programs.

This report summarizes the findings of the followup survey of the professional characteristics and work patterns of persons receiving support for their education under the training grants and fellowship programs of the National Institute of Meneal Health. Results from only the four core mental health disciplines of psychiatry, psychology, social work and psychiatric nursing will be discussed. This furnishes a general view of the current work of a sample of the individuals who received NIMH stipends during their mental health training. When the additional questions are tabulated, some time in 1974, further information will be provided on the career patterns of these individuals and how their employment and activities have changed over the years.

This survey was conducted in November 1972, and answers pertain to activities at that time. Quetionnaires were mailed to over 9,000 NIMH trainees in the four professional mental health disciplines, approximately one-third of those who had received stipends from 1948 to 1968. The latter year was chosen as a cutoff date in recognition of the fact that a large proportion of those supported later would still be in training at the time of the survey. This preliminary report covers answers to 15 of the questions which were selected for early analysis. A later report will cover all 54 questions, and fellows as well as trainees.

Tables I and II show the primary and secondary activities of the former trainees, and their places of principal employment. The following discussion will summarize the findings on each discipline separately.

TABLE I.—PRIMARY AND SECONDARY ACTIVITIES OF FORMER NIMH TRAINEES, BY DISCIPLINE

[In percents]

Activity	Psychiatry		Psychology		Social work		Psychiatric nursing	
	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary
Administration	13	9	11	8	20	11	20	8
Supervision	13	33	11	26	13	35	20	41
Teaching	3	15	25	11	11	5	27	18
Clinical services	66	13	37	12	46	15	26	11
Consultation	1	20	4	18	6	28	5	19
Research	3	5	11	24	1	5	1	2
Other	1	1	1	1	3	2	1	1
Total percent	100	100	100	100	100	100	100	100

TABLE II.—PLACE OF PRINCIPAL EMPLOYMENT OF FORMER NIMH TRAINEES, BY DISCIPLINE

[In percents]

	Psychiatry	Psychology	Social work	Nursing
Institutions of higher education	15.3	46.3	15.6	37.8
College or university	(1.0)	(40.0)	(12.1)	(13.5)
Medical schools	(14.1)	(5.9)	(1.5)	(0.3)
Other health professional schools	(.2)	(.4)	(2.0)	(24.0)
Hospitals and clinics	35.0	32.[illegible]	58.2	52.0
Community mental health centers	(13.9)	(13.[illegible])	(16.7)	(11.2)
Hospitals, residential treatment centers	(18.2)	(15.4)	(21.5)	(37.4)
Clinics, other social or health service organizations	(2.9)	(4.1)	(20.0)	(3.4)
Agency or organization in health, education or welfare not providing direct service	1.5	2.3	8.0	4.[illegible]
Elementary or secondary school system	.3	4.7	8.0	2.2
Private practice	45.7	7.5	3.2	1.9
Other	2.2	6.5	7.0	1.8
Total percent	100.0	100.0	100.0	100.0

PSYCHIATRY

Replies were received from 1,583 former trainees in psychiatry, about 67 percent of those to whom questionnaires were mailed. These individuals, for the most part, received support for their residency training in clinical or child psychiatry. Ninety-five percent are working as psychiatrists and, as table I shows, most are primarily engaged in the delivery of clinical services.. To another question, 98 percent said that they provide direct service to patients. Supervision, administration, teaching, and consultation also occupy a great deal of the psychiatrists' time.

Almost half of this group of respondents listed private practice as their primary employment, but 35 percent worked principally in hospitals and clinics (including community mental health centers) and 15 percent in universities and medical schools. Other studies have shown that most psychiatrists are employed in more than one setting, so table II may understate the actual diversity of work locations.

The major specialty areas given were clinical psychiatry (55 percent), child or adolescent psychiatry (23 percent), psychoanalysis (8 percent), and community psychiatry (7 percent). Fifty-nine percent of the sample reported that they now or have in the past worked in community mental health centers, over half of these for at least 2 years. Of those who currently work in the centers, 27 percent are employed approximately full time and 35 percent work there 10 hours or less per week.

PSYCHOLOGY

Responses were received from 1,490 former psychology trainees, 65 percent of those on the mailing list. These individuals received support through grants either in clinical and other applied areas or in research areas of psychology. Eighty-five percent are now employed in fields related to their training, 9 percent have not yet started professional work, and the rest are retired, working in other fields, or unemployed, often because of family responsibilities. Only six people reported that they could not find a suitable job.

The provision of clinical services is the most cited primary activity of the psychologists, but it can be seen in table I that they are also heavily engaged, as a group, in teaching, supervision, research, consultation, and administration. Almost half give institutions of higher education as their principal employers, and 33 percent spend most of their time in hospitals, community mental health centers, or other service organizations. The rest are in private practice or work for school systems, research laboratories, or a variety of other oragnizations.

The range of specialty areas for these psychologists is wide, but there is a heavy concentration (51 percent) in the area of clinical psychology. Twelve percent are in child or developmental psychology, 7 percent in educational or school psychology, and approximately 6 percent each in experimental, community, and social psychology.

Seventy percent of the psychologists report that they do provide some services to patients or clinics, and over 40 percent have worked or are now working in a community mental health center. Of these, 58 percent have worked in the centers for 2 years or less. Over half of the psychologists now working in a CMHC are employed there full time (36 hours a week or more) and 24 percent work between 1 and 10 hours a week in the centers.

SOCIAL WORK

Questionnaires were returned by 2,11[illegible] former NIMH-supported trainees in social work, most of whom were studying for their master's degree. This constitutes a response rate of 64 percent. Eighty-one percent of the social workers were employed in positions related to their training, 4 percent were employed in unrelated fields, 1 percent had not yet started working, and 14 percent were unemployed, most of these because of family responsibilities.

The provision of clinical services was listed as the primary activity for the largest group of social workers, and supervision was the most important secondary activity. Administration and consultation were also major responsibilities, followed by teaching and, to a lesser extent, research. Seventy-eight percent of the group provide some direct services to patients or clients. Nearly three out of five (58 percent) of the employed respondents were working in hospitals, community mental health centers, or social welfare clinics. An additional 16 percent were in institutions of higher education, and 8 percent each in school systems and "other" health, education, or welfare agencies. Almost all (94 percent) of the employing organizations were either public or private nonprofit.

One-third of the group specialized in psychiatric social work, 15 percent in therapy or counseling and 7 to 8 percent each in school social work, child welfare, community organization, and medical social work. Some 38 percent of the respondents have had experience in community mental health centers, about half of these having worked there for 2 years or less. About two-thirds of those currently working in the centers do so on a full-time basis.

PSYCHIATRIC NURSING

Responses were received from 858 former NIMH trainees in psychiatric nursing, most of whom were supported for study leading to the master's degree. The response rate was 58 percent. Eighty percent of the nurses were working in fields related to their training, and most of those who were unemployed gave "family responsibilities" as the reason.

The activities of this group are diverse. Teaching and supervision are the major primary and secondary activities listed, but the provision of clinical services, administration, and consultation are also important parts of the nurses' work. Little time seems to be spent on research. Two-thirds of the nurses provide services to patients and a third do not. Over half of the group are working in hospitals, clinics, or community mental health centers, and 38 percent in institutions of higher education, such as schools of nursing or colleges and universities.

Psychiatric mental health nursing is the specialty area listed by a majority of the nurses (54 percent; an additional 4 percent are in therapy or counseling, 3 percent in child psychiatric nursing, and 3 percent in clinical psychiatry. Fifteen percent specialize in nursing education. Other areas include medical and surgical, public health and school nursing. Thirty-seven percent of the responding nurses report experience in community mental health centers, but only a third of these have been employed by a center for more than 2 years. More than half (51 percent) of the nurses who currently work in the centers do so on a full-time basis, and 24 percent work there 10 hours a week or less.

Mr. Flood. Will you also please provide the committee with a copy of the report?

Dr. Plaut. Yes, sir.

PHASEOUT OF SUPPORT FOR MENTAL HEALTH TRAINING PROGRAMS

Mr. Flood. In this proposal to phase out mental health training support, which is in the budget, is that essentially the same as you had in last year's proposal?

Dr. Egeberg. Yes, sir; the mental health training grants go partly to the institution to strengthen it and partly to the students.

Mr. Flood. Last year you proposed to fund some new kinds of training programs which you called demonstration projects, developmental activities, and things like that, and continuing education. Dr. Brown was very enthusiastic about this. So we all were. This year despite all of that, they seem to be out along with all of the other training programs. What happened? Did something happen on the way to the forum or what?

Dr. Egeberg. There is a broad feeling in the administration that training grants have accomplished what they were meant to accomplish. Categorical support for training programs are no longer considered to be a direct Federal responsibility and they are being phased out. This applies to all training programs except the research fellowships program which will be continued.

Mr. Flood. For the record let's have a statement containing all the persuasive arguments that you can think of for the phasing out of the NIMH training programs. And, two, the revised versions of the two tables on pages 26 and 27 of the justifications reflecting when you do the 1973 appropriations that were released in 1974.

Dr. Egeberg. I think they are reflected.

Mr. Flood. This is for the record. Two, funding grants of 2 years and three, the comparable amount in 1972 and 1973. You can see what I am doing.

Dr. Egeberg. You are going back to 1972.

Mr. Flood. Watch your flanks.

A table showing the number of trainees supported, and by academic field, in 1971, 1972, 1973, 1974, and 1975.

[The information follows:]

Rationale for Phaseout of Training Programs

Manpower and training support activities were inaugurated in 1947 to help meet a nationwide shortage of mental health manpower required to satisfy growing demands for mental health services. Federal support involved two closely interrelated components:

1. Assistance to medical schools and other health-related professional and academic institutions to develop their teaching capability in psychiatry, psychiatric nursing, psychiatric social work, and psychology.

2. Assistance to students through stipends for professional training in mental health fields.

These two basic thrusts have continued to date, with training funds being about equally distributed between the two components. Today, the great majority of professional schools and academic institutions providing graduate education in mental health specialties derive some significant portion of their funding for teaching activities from NIMH programs. Similarly, though to a somewhat less extent, students entering these fields receive financial support through NIMH stipends. In addition, students not receiving direct stipend support, benefit from institutional teaching capability developed through NIMH support.

It is now believed that these programs of Federal support in mental health manpower and training are no longer required. Professional schools and academic departments, having built a reasonable teaching capability through NIMH support, should now be able to compete for continued funding from other sources. Graduate and postgraduate students entering the mental health professions can secure loans or, where eligible, apply for the expanded general educational assistance available to all graduate students through the Office of Education.

Although some mental health manpower shortages still exist in some geographic areas, it is felt that these can best be met through local rather than Federal initiatives. Overall, the current production rate of professionally trained mental health manpower, and the size of the current national manpower pool, appear to be adequate to meet current demands for services.

With respect to the field of psychiatry, there is a continuing and substantial inflow of foreign medical graduates who enter this specialty, again serving to offset the need for special Federal support to increase the numbers of physicians in this field.

It is felt that the same general principles also apply to training activities in research training, experimental training, continuing education and paraprofessional training. It should be noted that it is proposed to continue a small program for postdoctoral research fellows in priority mental health research areas for which a manpower shortage has been established. Similarly, it is felt that there is no need to continue a program of technical assistance to State and local mental health authorities since such assistance can be obtained from sources other than the Federal Government.

In accordance with the foregoing, therefore, all mental health manpower and training activities are proposed for phaseout, beginning in fiscal year 1975 (except for the small program for postdoctoral research fellows).

No new awards are projected for any training grants (either for institutional or student support) during fiscal year 1975. Technical assistance activities to States and localities in the area of training and manpower development will also be phased out in fiscal year 1975.

MULTIYEAR FUNDING OF TRAINING GRANTS

In fiscal year 1972, eight training grants totaling $936,000 received full funding on a multiyear basis. Of these, three grants totaling $404,000 were National Institute of Mental Health training grants, while the remaining were administered by the National Institute on Alcoholism and Alcohol Abuse. In fiscal year 1973, five training grants totaling $485,000 received full funding on a multiyear basis from the National Institute on Drug Abuse.

TRAINEE STIPEND AND RESEARCH FELLOWSHIP AWARDS, FY 1971-1975

	Number of Trainee Stipends or Fellowship Awards				
Discipline or Program	1971	1972	1973 1/	Est. 1974	Est. 1975
Training Grants	9,853	9,801	6,817	8,596	5,762
Psychiatry	3,560	3,342	1,480	2,585	1,422
Graduate	(1,820)	(1,852)	(1,375)	(1,759)	(1,296)
"Undergraduate"	(1.407)	(1,310)	-	(655)	-
General Practitioner	(333)	(180)	(105)	(171)	(126)
Behavioral Sciences	3,032	3,275	2,753	3,111	2,294
Psychology	(2,022)	(2,241)	(1,879)	(2,129)	(1,569)
Social Sciences	(580)	(551)	(537)	(523)	(386)
Biological Sciences	(401)	(428)	(315)	(407)	(300)
Special Programs	(29)	(55)	(22)	(52)	(39)
Psychiatric Nursing	1,328	1,287	812	1,098	718
Social Work	1,420	1,476	1,044	1,402	1,033
Experimental/Special	513	328	605	312	230
Continuing Education 2/	-	-	-	-	-
New Careers	-	93	123	88	65
Fellowships	677	553	198	137	305
Predoctoral	546	387	129	-	-
Postdoctoral	90	100	39	125	277
Special	41	66	30	-	-
Institutional Awards	-	-	-	12	28

1/ These are the numbers of stipends that could be supported under the policy of program phase-out. Restoration of funds appropriated in FY 1973 made it possible to provide additional stipends, but the numbers of such additional awards cannot be reported accurately at this time.

2/ Trainee stipends are not usually provided in continuing education programs since, in general, the training is on a short-term or part-time basis.

April 11, 1974

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

1975 CONGRESSIONAL JUSTIFICATION SHOWING "TRUE" PROGRAM LEVELS

(Amounts in thousands)

	1974		1975		Increase or Decrease	
	NO.	AMOUNT	NO.	AMOUNT	NO.	AMOUNT
General Mental Health:						
Training Grants:						
Continuation.................	751	$43,092	1,063	$60,401	312	$+17,309
Competing Renewals...........	1,088	55,065	---	---	-1,088	-55,065
New Projects.................	125	7,551	---	---	-125	- 7,551
Supplementals................	(1,508)	12,188	---	---	(-1,508)	(-12,188
Total, General Mental Health Training Grants.................	1,964	117,896 1/	1,063	60,401 2/		-57,495

1/ Excludes $1,500,000 multi-year funded.
2/ Includes $900,000 multi-year funded out of 1974 funds.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

1975 CONGRESSIONAL JUSTIFICATION SHOWING "TRUE" PROGRAM LEVELS

(Amounts in thousands)

	1974 AMOUNT	1975 AMOUNT	Increase or Decrease AMOUNT
General Mental Health:			
Training:			
Experimental and special....	$13,749	$ 4,487	$-9,262
New careers................	499	70	-429
Continuing Education........	2,046	105	-1,941
Psychiatry 1/..............	43,511	21,131	-22,390
Epidemiology...............	331	239	-92
Psychiatric nursing.........	12,234	5,990	-6,244
Social Work................	17,036	9,285	-7,731
Behavioral Sciences.........	28,490	19,094	-9,396
Total, General Mental Health Training Grants...............	117,896 2/	60,401 3/	-57,505

1/ Includes General Practioner Training Program

2/ Excludes $1,500,000 multi-year funded.

3/ Includes $900,000 multi-year funded out of 1974 funds.

DECLINE OF HEROIN ADDICTION

Mr. FLOOD. Are there grounds for believing that heroin abuse is on the decline?

Dr. EGEBERG. Yes, sir. The man sitting behind me can speak very clearly to that, Dr. DuPont.

Dr. DUPONT. One of the main indicators reflecting the decline has been the reduced demand for treatment relative to the total treatment capacity. As a consequence waiting lists of heroin addicts seeking treatment are virtually a thing of the past, particularly in the larger cities of the United States.

Simultaneously there has been a reduction in the overdose death rate and a reduction in the serum hepatitis rate related to the abuse of heroin. This decline in heroin abuse is now a common report from most cities in the United States.

Mr. FLOOD. Give us any statistics that you have on the incidence of heroin addiction compared with past years for the number of years you think would show the picture.

Dr. DUPONT. Yes, sir.

[The information follows:]

STATISTICS ON THE INCIDENCE OF HEROIN ADDICTION

A number of indicators illustrate the downward national trend of heroin addiction.

1. New heroin addicts reported to the Bureau of Narcotics and Dangerous Drugs (BNDD) by State and local jurisdiction during the years 1967 to 1972 increased from 6,009 to 22,383, but dropped to 16,446 in 1973.

2. The National Institute on Drug Abuse reports that during the period 1966–73, of the number of patients admitted for treatment of heroin abuse for the first time at reporting clinical facilities in 32 indicator communities, those who used the drug for the first time rose from 675 in 1966 to a peak of 1,583 in 1969, and then dropped to 115 in 1973.

3. The Drug Enforcement Agency reports heroin-related deaths in the United States have declined significantly, with 24 cities reporting a total of 51 during the second quarter of fiscal year 1973, 15 during the third, and 14 during the fourth.

4. The Drug Enforcement Agency also reports that in 24 major U.S. cities the number of narcotic (including heroin) addicts dropped by 15,964 from June 30, 1972 to June 30, 1974.

Mr. FLOOD. To what do you attribute this decrease in heroin addiction?

Dr. DUPONT. There are three factors that have contributed to it. First is the availability of treatment. For many years in this country people addicted to heroin had no access to treatment. Their only recourse was to manage their habit by turning to the pusher which necessitated, in many cases, adjusting to a criminal lifestyle. So that is one.

Second, the law enforcement and international efforts aimed at reducing the supply of heroin have had a remarkable degree of success particularly in the last 18 to 24 months.

Finally, and perhaps most importantly, there is a considerable change in community attitudes, particularly among young people who now see the self-destructive aspects of heroin use.

Mr. FLOOD. How long have you been onboard, Doctor?

Dr. DUPONT. I have been fighting the heroin problem for 5 years, first with the District of Columbia.

Mr. FLOOD. In this shop?

Dr. DUPONT. I have been with this shop 9 or 10 months.

Mr. FLOOD. You have been around town 9 or 10 years?

Dr. DUPONT. Since 1966.

NUMBER OF MARIHUANA USERS

Mr. FLOOD. Is use of marihuana increasing?

Dr. DUPONT. No, it is not. In part, the number of marihuana users appears to have stabilized within the last year or two, which is a remarkable finding.

It appears that among the adults in the United States, that is, people who are 15 years of age and older, that about one in seven have used marihuana. That number has been relatively constant for the last 2 years. This is a change from the previous 6 or 8 years when each year saw a rather dramatic increase over the previous year. I don't want to make too much of that but it is a change from progressive increases to relative leveling off in terms of the amount of marihuana used in the United States. We estimate there are about 13 million people in the United States who now use marihuana on a regular basis and about 25 or 26 million who have used it at least once.

Mr. FLOOD. With all of the research going on in connection with marihuana and the use of marihuana, what does it indicate with relation to harmful effects, if any, from the use of marihuana?

Dr. DUPONT. I don't think one can say marihuana is a safe drug. On the other hand we have not found to be true the dire predictions of earlier years which forecast serious physical problems arising from use of the drug.

At the moment our primary concern is with the effect of the intoxication itself; for example, on driving performance studies have shown that marihuana intoxication can affect both motor and intellectual performance. Marihuana smokers, like people who drink alcohol, often recognize that they should not use the drug when they have to concentrate. It diminishes their ability to perform work and drive vehicles. In terms of long term——

HARMFUL EFFECTS OF MARIHUANA

Mr. FLOOD. Harmful effects?

Dr. DUPONT. A number of question marks still remain but we have not found chronic harmful effects from the use of marihuana. We are concerned about the long-term effects of regular use of large amounts of marihuana over time.

We are still quite concerned about the irritant effects on the lung of inhaling a foreign substance. This concern is similar to the problem of tobacco smoking. I would point out to you, Mr. Chairman, that marihuana smokers, unlike cigarette smokers, rarely smoke continuously throughout the day. Even a heavy marihuana smoker rarely smokes more than once or twice during the day whereas, as you know, the typical cigarette smoker smokes 10 to 20 cigarettes a day. So the amount of irritants entering the lung is quite different in the two situations.

Mr. FLOOD. When you say smoking of marihuana cigarettes, is the reaction immediate?

Dr. DUPONT. Yes, sir.

REDUCTION IN BUDGET REQUEST FOR DRUG ABUSE PROGRAMS

Mr. FLOOD. Dr. Egeberg, has the situation with respect to drug abuse improved any at least to the effect that we can afford to cut in the spending for all of your drug abuse programs? Can we afford to cut this by $55 million as is proposed in the budget?

Dr. EGEBERG. There are a number of reasons why this is logical. I would rather Dr. DuPont gave them.

Mr. FLOOD. A number of reasons why it is logical to cut $55 million in the drug abuse program?

Dr. DUPONT. It is not logical to reduce our capacity to respond to the drug abuse problem. This budget, while it appears to indicate that, in reality does not for a number of reasons.

The primary one is that we had funds available for fiscal year 1975 in the Department of Health, Education, and Welfare from fiscal 1973, these were not impounded funds but funds appropriated with 2-year availability. Because of this, these funds are available for obligation in fiscal year 1974.

Since we have sufficient funds to in our fiscal year 1974 appropriations to maintain present treatment capacity we will utilize $17 million of these funds to pay fiscal year 1975 continuation commitments.

In addition we had a number of treatment service contracts that were of a 1-year nature; these were set up to deal with the crisis facing us a year ago. This crisis has been met and we are now able to meet treatment demands within our regular treatment service programs.

Finally there is a reduction in the amount of Federal participation in these programs as most grants are funded with a declining matching Federal rate.

I am saying that there is no programmatic reduction in our ability to provide treatment for drug abuse reflected in the fiscal year 1975 budget even though the numbers might, at first sight suggest the contrary.

Mr. FLOOD. I will tell you what you do. That is quite a statement. This is an appropriations committee. Will you try when you get the record to translate that for the record into dollars and come out with $55 million. I dare you.

Dr. DUPONT. I think I can come close and will accept the challenge.

[The information follows:]

EXPLANATION OF $55 MILLION REDUCTION IN DRUG ABUSE

The reduction of $55,799,000 in drug abuse programs is the net result of a number of changes. The majority of the reduction occurs in the Institute's training program and community program of project grants and contracts for treatment and rehabilitation and demonstration.

The reduction in the training program area is $5,169,000 and reflects the Administration's decision to phaseout Federal support for categorical training programs.

The reduction for community programs is $60,649,000; however, this reduction is partially offset by an increase of $10 million for formula grants to States. Despite the reduction in the level of obligations for project grants and contracts, it is important to emphasize that our existing treatment capacity will be maintained at the current level of 95,000 slots in both fiscal years. This level is adequate to support not only all addicts who volunteer for treatment but others as well that will be brought into treatment programs, as a result of an expanded outreach program.

There are three major reasons why the Drug Abuse Institute will be able to maintain its existing treatment capacity despite a reduction in funds. First, since we already have adequate funded treatment capacity excess funds are available in 1974 to forward fund grants that would normally be funded in fiscal year 1975. The amount of money involved is $17 million. Rather than have these funds lapse in the current fiscal year, we are proposing that they be used to fund in advance the continuation costs of a number of grants that will require continuation support in fiscal year 1975. An alternative would have been to allow this excess to remain unobligated this fiscal year and increase our 1975 budget request by $17 million.

The second reason for the reduction results from the fact that a number of projects which will be funded in the current fiscal year will not require continuation support in fiscal year 1975. These are primarily contracts which were required for 1 year only to quickly expand treatment capacity in areas where the demand for services exceeded the capacity. In the future, this demand will be absorbed within existing community treatment facilities. The fiscal year 1974 level of these nonrecurring costs is approximately $14 million.

Finally, the majority of treatment project grants and contracts supported by the Drug Abuse Institute are awarded on a matching basis. This means that non-Federal funds are required to match Federal funds awarded on each project. Under existing regulations the non-Federal share for each project increases annually thus reducing the Federal commitment. This decrease in the Federal share of each project accounts for most of the remaining reduction in community program funding requirements.

Mr. FLOOD. The Secretary recently wrote me a letter, Doctor, proposing to reprogram $10 million from project grants to formula grants in fiscal 1974. Is this reprograming reflected in your budget request?

Dr. DUPONT. Yes, sir.

Mr. FLOOD. And then, of course, for the record you will show us to what extent and why.

Dr. DUPONT. Yes, sir.

[The information follows:]

REPROGRAMING OF FUNDS FOR DRUG ABUSE FORMULA GRANTS

It is the intent that the Federal role in drug abuse activities shift in emphasis from the direct performance of drug abuse preventive functions to a more supportive role. Full attention is being given to preparing State and local agencies to become the primary focus of future prevention activities.

In light of this it is appropriate and desirable that $10 million be reprogramed from drug abuse treatment projects to formula grants. The funds are available for reprograming from the $31.9 million unobligated balance from the fiscal year 1973 appropriation carried over for use in fiscal year 1974. This will provide States with additional resources to assume a greater responsibility for all phases of drug abuse programs including planning, treatment services, information development and reporting, prevention, training and program administration.

FORMULA FOR DISTRIBUTING DRUG ABUSE GRANTS TO STATES

Mr. FLOOD. Are you proposing a change in the formula for distribution of the formula grants in drug abuse?

Dr. DUPONT. Yes, sir, we are.

Mr. FLOOD. Tell me about that change in the formula and when will the new formula go into effect?

Dr. DUPONT. The new formula will go into effect in fiscal 1974. Basically it represents a relatively modest change made in response to requests by the States. We have moved away from a special formula for drug abuse to the general Health, Education, and Welfare formula, which States are much more comfortable working with.

EXTENT OF ALCOHOL PROBLEM

Mr. **Flood**. Doctor, will you give whatever statistics you have. You gave some attention to it in your statement. Will you give us whatever statistics you have which indicate the extent that alcoholism still exists, how many alcoholics in the United States, is the problem getting better, is it getting worse.

Dr. **Egebert**. I think Dr. Chafetz would like to say a few words on this.

Dr. **Chafetz**. I was struck with your questioning of Dr. DuPont about the apparent decrease in heroin in this country as well as the apparent stabilization of the former increase of marihuana use. The same does not hold true in the situation of alcohol abuse and alcoholism. As a matter of fact, there is increasing evidence that the reason perhaps that young people are no longer using heroin, and not increasing their use of marihuana, is because they switched to our drug, alcohol; there is increasing evidence that along with the increasing use there are increasing problems.

For example, a recent comparison of the FBI Uniform Crime Statistics show that among young men below the age of 18, there was a 200-percent increase in arrests for alcohol intoxication in the 10-year comparative study, and among women below the age of 18, the arrest record for alcohol intoxication rose by better than 300 percent. There are other indicators that show that the big switch is on from other drugs to alcohol with, of course, the attendant problems that the adult population has already suffered and is continuing to suffer.

Mr. **Flood**. Is there any indication that the money that has been spent in combating alcoholism—we started the attack in the past several years—has had an effect?

Dr. **Chafetz**. I think we must be realistic. As you well know, Mr. Chairman, this has been a problem that goes back to the beginning of our country and this is really, with the creation of the National Institute some 3 years ago, the first concerted Federal attack on this.

I would loath to tell you that we have licked the problem, as much as I would like to say that. I think we have made important inroads.

For example, since the creation of the Institute all 50 States now have significant alcoholism programs going. Forty-nine of the 50 States have occupational alcoholism programs going. The Indian people who have been ravaged by alcoholism, with twice the national incidence, have their own Indian alcoholism program going and showing remarkable changes.

Let me give you some statistics. Prior to the establishment of the NIAAA Indian alcoholism program, no self-respecting Indian person would go to AA. The attendance of the group setup among the Indian people was zero.

In the interim, since we have begun funding Indian alcoholism programs, there are more than 100 AA groups for Indian people. The recovery rate in their program shows us that 50 percent are recovering in remarkable ways as reflected in their drinking patterns, in their ability to earn a living and get off welfare rolls. We are very enthusiastic.

I must say to you that our evaluation systems show in other areas, some of our money is not bringing the results we want. Some of the people are still doing more of the same, waiting for the late stages, not reaching out, and we have to make some important impact.

Mr. FLOOD. That is an excellent statement you have made on both questions.

Dr. CHAFETZ. Thank you.

PROPOSED REDUCTION IN APPROPRIATION FOR NIAAA

Mr. FLOOD. It makes me ask this question: The budget proposes to cut appropriations for alcoholism, all the programs, despite what you have just said, $38 million. Why do you cut it? Is that because the problem has become, in spite of what you say, less serious or is the program despite what you said ineffective or are there other reasons?

Dr. CHAFETZ. I think, as you well know, as chairman of the Appropriations Subcommittee, money doesn't always reflect interest in seriousness of a problem. I think that the issue is as follows:

Of course you recognize as well as I that this is an unusual budgetary exercise because we have the release of impounded 1973 moneys as well as the increased appropriations for 1974.

For example, in the category of research, the President's budgetary request shows an increase in research money. Training and community assistance decrease but there are very good reasons for that.

First of all, remember that the alcoholism program has a strong formula grant program.

Mr. FLOOD. Programs. What I am asking about is the $38 million cut in programs.

Dr. CHAFETZ. You have got to remember, Mr. Chairman, many of our projects and programs were demonstration studies, and they are reaching the conclusion of their studies with the intent and hope that State and local communities will take over their financing.

Mr. FLOOD. Of course you are asking now $1,700,000 for research contracts.

Dr. CHAFETZ. Yes, sir.

PROPOSED INCREASES IN 1975 FOR ALCOHOL RESEARCH CONTRACTS

Mr. FLOOD. To whom do you award these contracts? You want $1.7 million for contracts. Who gets the contracts, what kind of research?

Dr. CHAFETZ. One of the things we are busily studying, Mr. Chairman, is the fact——

Mr. FLOOD. Who gets them in the first place?

Dr. CHAFETZ. Strangely enough we have put out a RFP for private——

Mr. FLOOD. Better translate that for the record.

Dr. CHAFETZ. I may not be able to. That is a request for a proposal, published in the Commerce Business Daily, for private profitmaking organizations, private nonprofit institutions, universities, or other institutions to do some specific kind of alcoholism research under contract. The $1,700,000 in the 1975 budget for research contracts will be used for contracts to study the drinking practices and/or characteristics of alcohol abusers, innovative treatment techniques, and the interaction between alcoholism and other diseases. The results of the studies will be available for publishing in the third special report on alcohol and health to be submitted to Congress in 1976.

ST. ELIZABETHS HOSPITAL

Mr. **Flood.** There is no budget request before the committee for 1975 for St. Elizabeths Hospital, because it is proposed to transfer the Hospital to the District of Columbia. Has legislation to transfer the hospital been introduced in Congress? If so, when was the legislation introduced?

Dr. **Plaut.** Identical pieces of legislation have been introduced in the House and Senate. On July 20, 1973, Representative Quie introduced H.R. 9457 which was referred to the Committee on Education and Labor. On August 2, Senator Javits introduced S. 2325, which was referred to the Committee on Labor and Public Welfare.

Mr. **Flood.** Have hearings on it been scheduled?

Dr. **Plaut.** No, sir.

Mr. **Flood.** Is there any indication whatever that Congress might act favorably on such legislation?

Dr. **Plaut.** To my knowledge, we have received no definite indications either for or against the legislation. My impression is that congressional opinion generally favors the principle of transfer to the District, but there are some differences of opinion over the matter of timing.

Mr. **Flood.** How long do you plan to wait before sending up a budget request for 1975?

Dr. **Plaut.** Since the transfer legislation is still pending, we propose to wait until the legislation is acted upon. If the transfer legislation has not been acted upon by June 30, 1974, we plan to submit a request for special continuing resolution authority to continue the operation of St. Elizabeths, into 1975, under its present Federal status.

Mr. **Flood.** Please place in the record the proposed 1975 budget for St. Elizabeths Hospital.

Dr. **Plaut.** I will be happy to do so. This will be the budget which assumes the transfer, and requests the establishment of a Federal payment to the District of Columbia.

[The material follows:]

St. Elizabeths Hospital (Reflects Proposed Transfer to District of Columbia)

APPROPRIATION ESTIMATE

[St. Elizabeths Hospital]

[For expenses necessary for the maintenance and operation of the hospital, including clothing for patients, and cooperation with organizations or individuals in the scientific research into the nature, causes, prevention, and treatment of mental illness, $38 million or such amounts as may be necessary to provide a total appropriation equal to the difference between the amount of the reimbursements received during the current fiscal year on account of patient care provided by the hospital during such year and $59,524,000.]

(Department of Health, Education, and Welfare Appropriation Act, 1974.)

PAYMENT FOR SAINT ELIZABETHS HOSPITAL

For payments to the District of Columbia for the care of Federal beneficiaries at Saint Elizabeths Hospital, and in partial support of the cost of operation and maintenance of the hospital, $42,340,000.[1]

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[1] Legislation has been introduced proposing that the hospital be transferred to the District of Columbia. As part of the transfer arrangeent, the Department has proposed a new appropriation, "Payment for Saint Elizabeths Hospital."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

	1974	1975
Appropriation	$39,910,000	$42,340,000
Receipts and Reimbursements from:		
Federal funds	690,000	---
Trust funds	300,000	---
Non-Federal sources	22,408,000	---
Total obligations	$63,308,000	$42,340,000

Obligations by Activity

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Clinical & Community Services	4,132	$63,308,000	---	---	-4,132	-$63,308,000
Payment for Saint Elizabeths Hospital	---	---	---	$42,340,000	---	+$42,340,000
Total obligations	4,132	63,308,000	---	42,340,000	-4,132	-20,968,000

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Total number of permanent positions	4,132	---	-4,132
Full-time equivalent of all other positions	134	---	-134
Average number of all employees ...	4,125	---	-4,125
Personnel compensation:			
Permanent positions	$43,988,000	---	-$43,988,000
Position other than permanent ...	1,555,000	---	-1,555,000
Other personnel compensation	3,104,000	---	-3,104,000
Special personnel service payments	52,000	---	-52,000
Total personnel compensation	48,699,000	---	-48,699,000
Personnel benefits	4,210,000	---	-4,210,000
Travel and transportation of persons	240,000	---	-240,000
Transportation of things	117,000	---	-117,000
Rent, communications & utilities ..	936,000	---	-936,000
Printing and reproduction	42,000	---	-42,000
Other services	1,819,000	3,717,000	+1,898,000
Supplies and materials	6,155,000	---	-6,155,000
Equipment	937,000	---	-937,000
Lands and structures	176,000	---	-176,000
Grants, subsidies and contributions	---	38,623,000	+38,623,000
Insurance claims and indemnities ..	3,000	---	-3,000
Subtotal	63,334,000	42,340,000	-20,994,000
Deduct charges for quarters	-26,000	---	+26,000
Total obligations by object	63,308,000	42,340,000	-20,968,000

Summary of Changes

1974 estimated obligations	63,308,000
1975 estimated obligations	42,340,000
Net change	-20,968,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Program:				
1. Establishment of special account for payment to Saint Elizabeths Hospital	---	---	---	+42,340,000
Decreases:				
A. Program:				
1. Transfer of Hospital to District of Columbia	4,132	$63,308,000	-4,132	-63,308,000
Net Change	---	---	-4,132	-20,968,000

Explanation of Changes

Increases:

A. Program:

1. A new appropriation is proposed which will be used to reimburse the District of Columbia for treatment and care of Federal beneficiaries who will remain at Saint Elizabeths Hospital, and to pay a subsidy for the partial cost of care of District residents and partial costs of the Hospital's training and research programs.

Decreases:

A. Program:

1. Legislation has been introduced proposing that the organizational placement and administrative control of the Hospital be transferred from the Federal Government to the District of Columbia Government. Under the terms of the proposed legislation, the District Government will assume programmatic and budgetary responsibility for the Hospital on the ninety-first day after enactment of the legislation. This estimate assumes that the transfer will be effective beginning in FY 1975. The $20,968,000 net decrease in obligations results principally from the removal of reimbursement income from the Federal account. Under the terms of the transfer, reimbursement income will be budgeted for by the District of Columbia.

Justification

SAINT ELIZABETHS HOSPITAL

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits ..	4,132	$52,909,000	---	---	-4,132	-$52,909,000
Other Expenses	---	10,425,000	---	42,340,000	---	+31,915,000
Deduct charges for quarters	---	-26,000	---	---	---	+26,000
Total	4,132	63,308,000	---	42,340,000	-4,132	-20,968,000

General Statement

Legislation is now pending before Congress transferring the program and fiscal control of the Hospital from the Federal Government to the District of Columbia. Under the terms of the legislation, the District of Columbia will budget for and justify the operation of the Hospital under its own appropriations. An appropriation for a Federal payment to the District is proposed for FY 1975. Its nature and content are described in the material which follows.

a. Clinical and Community Services:

Saint Elizabeths Hospital provides treatment and rehabilitation for approximately 10,200 individual patients annually, with an estimated daily average of 2,950 inpatients and 2,750 outpatients. The Hospital operates a forensic psychiatry and security facility for the examination, treatment and rehabilitation of patients referred by the courts. The Hospital also operates a comprehensive community mental health center, which serves about 175,000 residents in the southeast quadrant of the District known as "Area D". Saint Elizabeths also provides treatment, care, and rehabilitation services for various patient categories including U.S. Nationals who become mentally ill while abroad, residents of the Virgin Islands and U.S. Soldiers' Home, and other categories of Federal beneficiaries. The Hospital conducts a clinical research program for the purpose of obtaining a better understanding of the causes of mental disorders, and the factors bearing upon their development, treatment and possible prevention. Saint Elizabeths also provides multi-disciplinary clinical training for professional and ancillary personnel engaged in or interested in mental health activities.

Transfer of Hospital

Over eighty-five percent of the inpatients and virtually all of the outpatients at Saint Elizabeths are residents of the District of Columbia. Transfer of the Hospital will provide needed local control over the treatment programs, and hospital operations affecting those patients. Local control will also ensure better integration with other mental health programs of the District's Human Resources Department. Further, transfer of this facility is expected to promote a more efficient operating relationship with the District's criminal justice system. The proposal is consistent with the Department's policy of state and local control of programs that provide direct patient treatment.

Under the terms of the proposed transfer, the District Government will assume budgetary responsibility for the Hospital on the ninety-first day after enactment of the transfer legislation. For planning purposes, the transfer of the Hospital to the District Government is assumed to be at the beginning of FY 1975; therefore, no funds are requested under this activity to support direct operation of Saint Elizabeths by the Department. DHEW payments to the District will be budgeted under a new appropriation, "Payment for Saint Elizabeths Hospital".

b. Payment for Saint Elizabeths Hospital:

Funds in this activity will be used to reimburse the District of Columbia for the full cost of treatment and care of Federal beneficiaries who will remain at the Hospital after the transfer, and to pay the first increment of what will ultimately be a subsidy to the District of Columbia. The subsidy will cover the partial cost of care of patients who are residents of the District, or who are eligible for treatment by the Hospital by reason of their having been found in the District. The subsidy will also cover the partial cost of clinical training and research. The proportion of Federal support to the total of the treatment, training and research costs specified above will remain relatively stable for the first five years (approximately 63 percent). From the sixth through tenth years, the level of support will decrease on a straight-line basis, reaching zero in the eleventh year. Ultimately, the Federal share of the operation will be limited to reimbursements for the treatment of Federal beneficiaries.

CLINICAL AND COMMUNITY SERVICES

Program Purpose and Accomplishments

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
4,132	$39,910,000	---	---	---

Purpose: Saint Elizabeths Hospital provides mental health treatment, care and rehabilitation services. The Hospital operates a security treatment facility and a comprehensive mental health center which services District of Columbia residents in the southeast quadrant of the city. Saint Elizabeths also conducts a clinical research program and provides multidisciplinary clinical training for professional and related personnel.

Explanation: The Hospital operates with an indefinite appropriation, which fixes a total operating ceiling and provides that direct Federal appropriations will make up the difference between the total authorized ceiling and the amount of reimbursements received during the year. Virtually all reimbursements received are for inpatient care. The principal reimbursing agency is the District of Columbia.

Accomplishments in 1974: The Hospital continued further implementation of the unit plan with emphasis on the team approach in the treatment and care of patients. Admissions reached an all time high of 4,300; however, by providing more intensive early inpatient care and through continued emphasis on the early return of patients to productive community life, the Hospital was able to discharge a record high 4,100 patients and to achieve a slight reduction in the average daily patient load. Over 10,200 patients were treated, including an average of 2,750 outpatients. The narcotic addiction program is being expanded to serve approximately 75 patients. Intensive care units are being established in the Medical and Surgical Branch.

Objectives for 1975: For budget planning purposes, Saint Elizabeths is to be transferred to the District of Columbia at the beginning of 1975.

PAYMENT FOR SAINT ELIZABETHS HOSPITAL

Program Purpose and Accomplishments

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	--	--	--	$42,340,000

Purpose: To provide an orderly transition from Federal to local control.

Explanation: This activity will be used to reimburse the District of Columbia for treatment and care of Federal beneficiaries who will remain at Saint Elizabeths Hospital, and to pay a subsidy to the District of Columbia. The subsidy will cover the partial cost of care of District of Columbia residents and partial costs of clinical training and research. Federal support will be approximately 63 percent of the Hospital operating costs during each of the first five years after transfer, and will thereafter decrease on a straight line basis to zero in the eleventh year. Ultimately the Federal share of the operation will be limited to reimbursements for the treatment of Federal beneficiaries.

Accomplishments in 1974: Legislation has been submitted transferring program and fiscal control of Saint Elizabeths Hospital from the Federal Government to the District of Columbia. Under the terms of the forthcoming transfer, the District will budget for and justify the operation of the hospital under its own appropriations.

Objectives for 1975: It is our goal that Saint Elizabeths Hospital will be placed under District of Columbia control as of July 1, 1974. Using the Federal payment mechanism and by providing technical assistance and guidance to the District, the Alcohol, Drug Abuse, and Mental Health Administration plans to assist the District of Columbia in its effort to convert Saint Elizabeths Hospital into a viable and effective component of the city's total mental health system.

SAINT ELIZABETHS HOSPITAL

Reimbursement Detail

	1974 Estimate	1975 Estimate A/
Reimbursements from Federal and Trust Funds:		
Veterans Administration	$19,200	---
U.S. Soldiers Home	38,500	---
Public Health Service (Indians)	57,700	---
U.S. Nationals	479,700	---
U.S. Prisoners	76,900	---
Soc. Sec. (Medicare payments)	300,000	---
General Services Administration	18,000	---
Subtotal	990,000	---
Payment received from Non-Federal sources:		
District of Columbia	22,309,000	---
Cafeteria sales	87,000	---
Sale of scrap	8,000	---
Washington Opportunity for Women	4,000	---
Subtotal	22,408,000	---
Total reimbursements	23,398,000	---

	1974	1975
Per diem rate:		
District of Columbia	$24.53	---
Other	52.69	---

A/ FY 1975 reimbursement income for the Hospital will be reported by the District of Columbia.

SAINT ELIZABETHS HOSPITAL

Statement of Average Daily Patient Population

	1973 Actual	1974 Estimate	1975 Estimate
Reimbursable			
Public Health Service (Indians)	3	3	3
D.C. (Residents)	1,849	1,736	1,679
D.C. (Vol. and Non-protesting)	467	540	550
D.C. (Prisoners)	223	223	220
D.C. (Jury Trial)	27	26	26
U.S. Soldiers Home	3	2	2
Veterans Administration	1	1	1
U.S. Nationals	29	25	25
U.S. Prisoners	6	4	4
Reimbursable Totals	2,608	2,560	2,510
Nonreimbursable			
Military	71	68	68
D.C. Non-residents	213	227	227
Public Health Service	3	3	3
Virgin Islands	70	70	70
Other	29	22	22
Nonreimbursable Totals	386	390	390
Total In Hospital Patients	2,994	2,950	2,900

Statement of Average Daily Patient Population

	1973 Actual	1974 Estimate	1975 Estimate
REIMBURSABLE:	2,608	2,560	35
D.C.	2,566	2,525	...
D.C. (Residents)	1,849	1,736	...
D.C. (Vol. & Non-Prot.)	467	540	...
D.C. (Prisoners)	223	223	...
D.C. (Jury Trial)	27	26	...
U.S.	42	35	35
U.S. Soldiers Home	3	2	2
Veterans Administration	1	1	1
U.S. Nationals	29	25	25
U.S. Prisoners	6	4	4
Public Health Service (Indians)	3	3	3
APPROPRIATION:	386	390	2,865
D.C.	...	...	2,702
D.C. (Residents)	...	...	1,679
D.C. (Vol. & Non-Prot.)	...	...	550
D.C. (Prisoners)	...	...	220
D.C. (Jury Trial)	...	...	26
D.C. (Non-residents)	...	...	227
U.S.	386	390	163
D.C. (Non-residents)	213	227	...
Military Services	71	68	68
Public Health Services	3	3	3
Virgin Islands	70	70	70
Other	29	22	22
TOTAL IN HOSPITAL PATIENTS	2,994	2,950	2,900

REORGANIZATION

Mr. MICHEL. Dr. Egeberg, in this reorganization of yours, is our mental health effort being downgraded? Did you wind up with alcohol, drug abuse, and mental health and wonder, "well, what can we do with these leftovers," and just lump them together for lack of anything better to do with them?

Dr. EGEBERG. I can assure you that the reorganization has in no way downgraded the mental health efforts carried out by the National Institute of Mental Health. Rather, the new organization gives appropriate visibility and leadership to the high-priority programs of drug abuse and alcohol abuse, as well as mental health and illness.

Furthermore, these Institutes were not combined without any specific purpose in mind. While each of these problems have some unique features, they are by no means completely unrelated. As mentioned in my opening statement there are a variety of interrelationships and cooperative endeavors among the programs of the three Institutes. For example, in treatment of these problems, 140 CMHC's or their affiliates provide drug abuse services, and 210 provide alcoholism services.

MENTAL HEALTH TRAINING GRANTS

Mr. MICHEL. The proposed reduction in the mental health training grants program for fiscal 1975 is actually $59.9 million in obligations, isn't it? And $34.6 million in budget authority? You are making new awards this year, but you propose to make no new awards in fiscal 1975, so that $59.9 million cut—which is almost exactly half the program dollars—represents only new awards, is that right? What is this group of people? Psychiatric training is the biggest single item in this group of training programs, isn't it? With behavioral science next, then special and experimental, then social work, and psychiatric nursing? As always, Doctor, we get down to the basic question—the nitty-gritty. Is there a need for these people to be trained, and if so, where can they turn for support?

Dr. PLAUT. During the phaseout of training programs in fiscal year 1975, NIMH intends to provide stipend support to all students who have received a commitment from their institutions. In fiscal year 1974, NIMH provided stipend support to 8,596 students. This number will be reduced to 5,762 in fiscal year 1975. There is a need for these people to be trained to fill positions in service, research, and training institutions since some mental health manpower shortages still exist in some geographical areas. If Federal stipends are not available for these students they will have to turn to other sources of support to underwrite their training. Money might be made available through stipends provided by the States using some of their revenue-sharing funds for this purpose. In addition, graduate and postgraduate students entering the mental health professions can secure loans or, where eligible, apply for the expanded general educational assistance available to all graduate students through the Office of Education.

NON-FEDERAL SUPPORT OF COMMUNITY MENTAL HEALTH CENTERS

Mr. Michel. With respect to the community mental health centers program, you say in the justification that "those programs which have operated efficiently will be able to obtain sufficient State, local, and private moneys and third-party reimbursements to continue to exist after their Federal support period has ended, as originally intended at the time of the legislation's initial enactment". Have you ever done a really serious study of the resources available to these programs, outside of Federal support? Can you really back up that statement with hard data, or is that more in the nature of a supposition on your part? Are you aware of any of these programs that have received revenue-sharing money?

Dr. Plaut. First of all, Mr. Michel, I would like to point out that data from 1972 indicates that the Federal staffing grant provides only 31 percent of the total operating costs of the average CMHC. The remaining sources of finance are as follows: State funds, 31 percent; receipt for services, 22 percent; local funds, 10 percent; other Federal funds, 4 percent, and miscellaneous, 2 percent.

In addition, we have initiated several programs to increase funding sources available to these centers. Over the past 6 years, NIMH has developed and expanded a staff directed program of technical assistance to community mental health centers through which fiscal and in-kind resources for services have been identified as generally available to centers. These include some 56 sources representing a variety of categories including philanthropy, negotiated contracts with State and local agencies and with unions, public and private insurance, and medical assistance programs, and a number of Federal support programs other than those administered by NIMH. The technical assistance program developed and conducted conferences on multiple source funding and on fiscal management for center and State personnel in each of the DHEW regions between 1970 and 1973; and training programs for State authority personnel on cost accounting, cost allocation, and rate setting (46 of the States and territories participated).

The NIMH is currently launching an expanded technical assistance effort under contract to improve the management capability and effectiveness of centers through a combined training/consultation/model-building effort directed to the development and effective utilization of management information systems within the approximately 450 federally funded centers nationwide. This effort is designed to increase the operational efficiency of centers in their continued efforts to obtain increased State, local, and private moneys and third-party reimbursements for services, and to continue to exist after their Federal period of support has ended. Hopefully this will reduce some barriers that exist within reimbursement mechanisms upon which centers now depend and will depend under a national insurance program. As an example, a study of two of these mechanisms, medicare and medicaid, which now contributes only 8 percent of center service support, concludes that, given a fully efficient and effective center management capability, reimbursements could represent about 20 to 25 percent of the centers' required income.

Further, some centers have in fact derived a limited amount of support from Federal revenue-sharing funds. The data on this source are too fragmented and limited however, as to indicate any definite trends.

COMPREHENSIVE HEALTH INSURANCE PLAN

Mr. MICHEL. You also say on that same page, "In addition, the administration's comprehensive health insurance plan (CHIP) is designed to cover virtually all acute mental health care and treatment on an equitable basis." Would you, for the record, spell out just how CHIP would provide support for community mental health progams? Would all of the services offered by these programs be eligible for CHIP coverage?

Dr. PLAUT. We will be happy to provide that information for the record.

[The information follows:]

FEATURES OF THE COMPREHENSIVE HEALTH INSURANCE PLAN

The Comprehensive Health Insurance Act of 1974 includes the same mental health care benefits in the proposed three programs. These are: the Employee Health Insurance Plan (EHIP) which will be offered to most Americans under 65 at their place of employment, the cost of which will be shared between the employer and employees; the Assisted Health Insurance Plan (AHIP), covering low-income, unemployed, seasonably employed, disabled and high-risk populations and those ineligible for the other two programs for which the Federal and State governments will subsidize those costs beyond the means of the insured; and the Federal Health Care Plan which will modify the benefits of medicare for the aged to conform with the mandated health benefits. Although mental health coverage will be identical, there will be different cost-sharing arrangements such as deductibles, coinsurance and maximum liability applicable to each program. Cost sharing under AHIP and medicare will essentially be income related.

As part of the stipulated minimum acceptable basic benefits required under this bill, the same coverage would be provided for such mental health related benefits as posthospital extended care, home health visits, and outpatient prescription drugs regardless of medical condition. The EHIP and AHIP, which will provide coverage for families with children include among the covered preventive services, well-child care up to 6 which can be effectively used for early case finding of emotional difficulties.

For treatment of mental illness, coverage for inpatient hospital services would be limited to 30 days per year with each day of partial hospitalization counting as one-half day of inpatient care. Coverage limits for mental health services provided on an outpatient basis would be an annual cash ceiling established by the Secretary in November of the previous calendar year. This amount would be the estimated cost of 30 outpatient visits to a private practitioner for the treatment of mental illness. The payment limit would be the full cash ceiling for services provided in a comprehensive community care center (as defined in regulations prescribed by the Secretary), and half of the cash amount when provided by a private practitioner or by those programs which do not meet the requirements established by regulations to qualify as a comprehensive community care center.

Benefit limits for covered services under CHIP are incorporated more frequently for mental health care than for other covered services. However, since the basic benefit package is the minimum acceptable level of coverage, a floor as it were, employers will be free to offer new supplemental benefits which can include more extensive mental health coverage. The millions of Americans now covered by existing more liberal mental health benefits will also have the opportunity to retain coverage at that level. Of particular importance is the fact that CHIP stipulates as minimum benefits more balanced and comprehenhive benefits: that is, inpatient, partial hospitalization, and outpatient services, than are currently available in most health insurance contracts and plans. Moreover, the stipulated universal benefit package is being proposed at a reasonable and economically bearable price tag for all Americans. The removal of major economic barriers to care should result in greater accessibility to a range of services which, it is hoped, will promote early case finding and treatment appropriate to the patient's need in the community in which the individual lives.

However, the ultimate implementation of the design of CHIP will initially be influenced by the regulations and guidelines that will be written upon enactment of the legislation. Not only will it be the responsibility of the regulations to define the various treatment modalities; that is, partial hospitalization to assure high quality and appropriate mental health care, but, equally important, the regulatory definition of comprehenhive community care center will give the opportunity to reflect the potentials and strengths of organized mental health service systems. We would hope that the contributions of such community mental health programs as federally funded CMHC's will be recognized in the regulations. The CMHC's have long and successful experience with comprehensive service programs and the appropriate balanced mix of treatment modalities to meet the patient's needs at different phases of his illness. Moreover, the choice of treatment modalities based on professional judgment rather than insurance coverage not only leads to more effective treatment, but has also been found to be less costly in the long run, both for the patient and his family and for society.

We anticipate that CHIP will enable CMHC's to continue to play a significant role in providing mental health services to the American people. It is likely that under a national health insurance program that diminishes the financial stress associated with obtaining adequate reimbursement and revenue sources, CMHC's will experience an overall increase in third party reimbursements for their service programs. In addition, we would hope that as a result of the incorporation of most of Medicaid into CHIP and the modification of the medicare for the aged benefits, the existing provider restrictions and benefits reimbursement limits of these programs will be carefully examined and either modified or eliminated.

Organized community mental health care systems such as CMHC's, by their nature and mandate, are especially important in the role of providing consultation and education to community agencies, professionals and such related human service programs as the schools, correctional systems, health care-providers, and so forth. It would have been salubrious for the mental health of the Nation if CHIP had been able to recognize the contribution of construction and education as insurable covered services.

Federally funds CMHC's must provide consultation and education as part of the basic mandated service program. In the absence of insurance coverage, CMHC's will have to seek continuing revenue to support these activities from other resources, presumably from State and local tax funds.

REDUCTION IN GENERAL MENTAL HEALTH MANAGEMENT AND INFORMATION

Mr. MICHEL. It isn't clear to me how much of the $6.4 million reduction in general mental health management and information is related to personnel and how much is a program reduction. Would you clarify that for the record, please?

Dr. EGEBERG. The President's budget was formulated at a time when fiscal year 1974 National Institute of Mental Health employment levels were to be decreased by 194 over those originally planned. This net reduction of $6,410,000 includes an increase of $1,176,000 in mandatory items such as within-grade increases and pay raises. The decrease related to the reduction of budgeted positions from the original fiscal year 1974 employment level is $3,678,000. The remaining reduction of $3,908,000 consists of program reductions unrelated to personnel.

I should point out, Mr. Michel, that a decision has been made to restore 1974 employment to its present level. Therefore we will require funds in excess of $16,753,000 to support operating costs in fiscal year 1975. We will therefore be making a request to this committee to reprogram funds from Alcohol or Drug Abuse research activities to meet these payroll demands.

VOLUNTEER HELP IN THE MENTAL HEALTH AREA

Mr. MICHEL. In this field of mental health, there is a tremendous amount of volunteer help and support across the country that is often overlooked. For the record, would you give us whatever information or estimates you have on the kind and amount of volunteer help provided nationally in the mental health area?

Dr. EGEBERG. There is a tremendous amount of citizen volunteer support and help for alcohol, drug abuse, and mental health programs across the country. Hundreds of thousands of citizens participate voluntarily in a variety of mental health activities. The forms of participation include rendering direct volunteer services, serving on mental health planning bodies, belonging to voluntary organizations having special services programs, supporting new community services, contributing to the growth and development of State and local mental health services through membership on citizen boards, and a host of other mechanisms affording opportunity for citizen volunteer contributions to community service efforts. Data covering all volunteer efforts in alcohol, drug abuse, and mental health programs is not available. I will provide information which is available for Community Mental Health Centers as an example of efforts that are being made.

[The information follows:]

STAFF POSITIONS IN FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS BY DISCIPLINE AND EMPLOYMENT STATUS, UNITED STATES, JANUARY 1973—ESTIMATED NUMBER OF POSITIONS

Discipline	Employment status				
	Full-time	Part-time	Trainee	volunteer	Total
Total all staff	23, 540	5, 802	2, 458	3, 690	35, 490
Psychiatrists—Board certified	375	484	0	28	887
Psychiatrists—Board eligible	373	504	0	19	896
Other psychiatrists	103	117	435	3	658
Psychiatrists, total	851	1, 105	435	50	2, 441
Other physicians	66	299	92	16	473
Psychologists—Ph.D	766	289	126	14	1, 195
Psychologists—M.A	821	180	104	27	1, 132
Other psychologists	152	33	110	32	327
Psychologists, total	1, 739	502	340	73	2, 654
Social workers—MSW (or M.A.) and above	2, 309	462	269	42	3, 082
Other social workers	715	92	206	52	1, 065
Social workers, total	3, 024	554	475	94	4, 147
Psychiatric nurses (M.S. and above)	296	60	65	11	432
Other registered nurses (R.N., A.A., B.S.N.)	2, 094	546	435	25	3, 100
Registered nurses, total	2, 390	606	500	36	3, 532
Licensed practical or vocational nurses	1, 048	132	19	7	1, 206
Other mental health professionals—B.A. and above	2, 745	417	245	433	3, 840
Mental health workers (less than B.A.) A.A. level	1, 306	298	136	753	2, 493
Other mental health workers (less than A.A. level)	4, 116	711	161	1, 655	6, 643
Mental health workers, total	5, 422	1, 009	297	2, 408	9, 136
Physical health professionals and assistants	105	149	17	50	321
Administrative and other professional (nonhealth) staff	950	192	17	20	1, 179
All other staff	5, 200	837	21	503	6, 561

INDIVIDUALS TREATED THROUGH ALCOHOL COMMUNITY PROGRAMS

Mr. MICHEL. Do you have any figures on how many individuals have received help through the 700 community programs?

Dr. CHAFETZ. We estimate that, since 1971, some 400,000 people have received help.

Mr. MICHEL. Do you have any figures on the number of individuals receiving treatment through other facilities?

Dr. CHAFETZ. No reliable figures are available concerning the number of individuals receiving treatment through other facilities. However, including people seen by physicians in private practice, general and psychiatric hospitals, and similar facilities, but excluding AA, it is believed that approximately 1 million people received some form of treatment for alcoholism problems in 1973. According to a recent survey, total visits to private practitioners where alcoholism was the primary diagnosis approximated 3.4 million in 1973. This figure, it should be noted, includes repeat visits.

Mr. MICHEL. Has the total number of individuals in treatment programs increased in the past few years? By how many?

Dr. CHAFETZ. The total number of people being treated in NIAAA-funded programs has been increasing at over 20 percent a year since fiscal year 1971. It is expected that, in fiscal year 1974, almost 170,000 people will be treated in the 450 alcoholism treatment programs directly supported by NIAAA. This excludes those that are treated in programs supported through NIAAA's formula grants. The comparable figure for fiscal year 1973 was 131,000—at which time NIAAA was directly supporting 352 alcoholism treatment programs.

Mr. MICHEL. What percentage of the 9 million people you mentioned as problem drinkers or alcoholics are involved in a program?

Dr. CHAFETZ. Approximately 10 percent of the problem drinkers and alcoholic people are involved in alcoholism treatment programs in any one year.

Mr. MICHEL. What kinds of efforts are being made to bring more problem drinkers into a treatment program, or do you, for the most part, have to wait until someone comes to you for treatment?

Dr. CHAFETZ. Very specific efforts are being made to bring more problem drinkers into treatment. This is best demonstrated in our community-based programs, such as the poverty programs, in which extensive outreach efforts are basic to the programs. Outreach workers and counselors are placed in strategic locations in the community such as neighborhood service centers where community residents obtain a wide variety of services. This provides the outreach worker with an excellent opportunity to identify problem drinkers and to encourage their participation in the alcoholism treatment program. Referrals from other health care providers, within the center, are readily accessible to the outreach worker.

Additionally, outreach workers are actively involved in conducting alcoholism education workshops in community organizations such as churches, schools and civic organizations, et cetera. To supplement this educational effort, radio and television stations donate blocks of time for alcoholism treatment personnel to discuss their programs and encourage persons with drinking problems to avail themselves of treatment services.

Affiliation agreements with other agencies such as social, welfare, hospitals, courts, et cetera, provide for a systematic mechanism for referrals to the alcoholism treatment program.

In our occupational programs, the primary thrust is the early identification of the troubled employee with a drinking problem, based primarily on declining job performance. The intent is to identify those persons and refer them to available community treatment resources before they become casualties of the work force.

The alcohol safety action program is extensively involved in outreach into the court system. Problem drinking drivers are identified and referred to treatment resources in the community.

The 45 alcoholism treatment centers which serve the general population, have an outreach component. Our data collection system reveals that an increasing number of referrals are being generated through this mechanism from general hospitals, clinics, and the court system.

RESEARCH OF GENETIC FACTORS IN ALCOHOLISM

Mr. MICHEL. You mentioned that several research projects give you an opportunity to explore the contribution of genetic factors in alcoholism. Have any projects shown a specific indication that alcoholism and/or its related problems are genetically induced?

Dr. CHAFETZ. A number of studies have suggested that alcoholism "runs in families." For example, approximately 30–35 percent of the brothers and fathers of alcoholic persons are themselves alcoholic and about 20–30 percent of the children of alcoholics subsequently become alcoholic adults. Although a genetic basis for alcoholism is suggested, it should be noted that most alcoholic persons are raised by their biological parents and, therefore, it becomes extremely difficult to separate the contribution of hereditary factors from environmental factors.

One study supported by the NIAAA addresses this very issue. The principal investigator has taken advantage of a unique register maintained in Denmark in which over 5,000 persons were identified who were adopted by nonrelatives. Comparisons were made between persons of alcoholic parents who were raised by their biological parents and those who were raised by nonalcoholic foster parents. This research suggests that a higher incidence of alcoholism occurs in persons raised by their alcoholic parents. This study is continuing and more data is needed before a definite conclusion can be made regarding the contribution of genetics to the development of alcoholism.

Other studies in this area have utilized genetically pure strains of mice which have markedly different alcohol ingestion patterns. "Drinker" mice and "nondrinker" mice are compared for possible biochemical differences. Such studies are focused on characterizing the various enzymes which metabolize alcohol and the sensitivity of the brain with a given dose of alcohol.

RESEARCH PROJECTS IN ALCOHOLISM

Mr. MICHEL. Do you have a breakdown of the 100 research investigations as to the number of projects involved in the direct treatment of an alcoholic and the number of projects involved in related problems such as the effect of the illness on the family?

Dr. CHAFETZ. Of the grants that are eligible for funding, 21 involve direct treatment of alcoholic subjects, and two involve related problems, such as the effect of the illness in the family.

Mr. MICHEL. For the record, could you provide a list of some of the major research projects presently underway, the amount of money involved in each, and the general information that each project is designed to explore?

[The information follows:]

The following 15 projects are representative of the wide range of areas being investigated under the auspices of NIAAA research grants. For each project, there is included the title of the project, the grant number, and a brief description of the work. These projects have been underway for at least 1 year and will continue at least through the next year. The funds shown have been awarded for conduct of the research, or, if in parentheses, will be awarded this fiscal year.

R18 AA00177-Epidemiology of Alcoholism in Latin America------ ($215,000)

This study of drinking patterns and prevalence in 10 Latin American sites is designed to determine the prevalence of alcoholsim and heavy drinking in urban, semirural and rural settings as related to type of beverage, age, sex, and cultural variables. Surveys in samples of the population, through questionnaires as well as the informat method, will be used. A Center for Studies on Alcoholism will be set up in Costa Rica. Two international seminars on traffic accidents and alcoholism will be held in two Latin American countries.

R12 AA00209—Washington University Alcoholism Research Center- ($325,000)

A broad range of projects are proposed for investigation: Aging, suicide, and alcoholism: a comparison between whites and blacks; alcoholism and criminality; a study of psychiatric illness in full siblings, half siblings, and adopted siblings of chronic alcoholic persons; genetic studies in alcoholism; state-dependent effects of alcohol in chronic alcoholic patients; psychological and physicochemical correlates of alcoholic blackouts; sleep and growth hormone secretion in alcoholic individuals; effects of alcohol on hypnogenic brain areas in monkeys; effects of alcohol and the biogenic amines on volitional alcohol intake in animals and effects of chronic alcohol intake on the brain during critical periods in development; brain biochemistry in human alcoholism and in animals drinking excessively; effects of chronic alcohol administration on the enzymes involved in catecholamine metabolism in rats; an endocrinologic study of alcoholic men.

R01 AA00232—Socialization of problem behavior in youth------------- $100,570

This is a longitudinal/cross-sectional study of the development of delinquency, aggression, use of drugs and of alcohol as related to socialization processes, personality, and social relationships. It will also study relationships of (1) alienation to opportunity perception, (2) deviance to socialization, (3) critical transition periods, and (4) adaptability to problem behavior. Study is arranged with controls for sex, social class, and ethnic group. Data will be collected through questionnaires, teacher ratings, school records, sociometrics, interviews, and factor analysis.

R01 AA0239—Effects of alcohol on liver and intestine-------------- ($110,000)

This is a project to study (1) effects of alcohol on lipid metabolism, (2) effects of ethanol on porphyrin metabolism and fatty acid oxidation, (3) effects of ethanol in intestinal transport, and (4) effects of ethanol on liver and intestinal cell membranes. Subjects are rats.

R01 AA00256—Psychiatric illness in adopted children of alcoholic persons --- ($80,000)

This investigator wishes to do a study of the male offspring of alcoholic persons who have been adopted and brought up by nonrelatives. His thesis is that if alcoholism is genetic, a significantly higher number of these individuals will have problems with drinking alcohol than a control group. This study will use data gathered in the NIMH-Denmark study of schizophrenia. Subjects are male adoptees, born in Denmark between 1924 and 1947 (age 23–46) whose biological parents have been admitted to a Danish psychiatric facility and have been diagnosed as chronic alcoholic individuals. Controls are male adoptees whose biological parents had no overt psychopathology.

R01 AA00267—Alcohol and its metabolic effects ($75, 000)

This project is concerned with the metabolism of alcohol and thiamine deficient states. Subjects are adult and newborn rats and guinea pigs. The animal subjects are vitamin depleted. Physical, chemical, and microscopic examinations for cardiac hypertrophy, liver malfunction, and brain damage are performed. Four groups of animals maintained under different regimes with reference to diet and alcohol are compared. Another line of research uses radioactive techniques to study the metabolism of bilirubin.

R01 AA00287—Effects of alcohol of subcellular organelles of liver ($185, 000)

The objective of this study is understanding of the effects of acute and chronic alcohol consumption on mitochrondria, endoplasmic reticulum, ribosomes, Golgi complex, and limiting membranes of liver cells. In vitro studies will be done with cells isolated from the liver of mature rats given ethanol acutely or chronically for varying periods of time up to 60 days.

R01 AA00292—The enzyme-substrate compound of catalase in alcoholism ($275, 000)

The object of this study is to identify the functional relationships of the components of the catalase pathway for ethanol and methanol oxidation at the molecular level and at that of the intact organ. Studies of catalase at the molecular level will seek to identify and to control the nature of the "peroxidatic" (alcohol-oxidizing) reaction. Heart and liver tissue are used. The ultimate objective is to develop treatment for the metabolic difficulties inherent in the alcoholic state.

R01 AA00297.—Zygotic and uterine mediated effects of alcohol $69,680

This investigation consists of a number of studies on the effects of maternal intake of ethanol on reproductive physiology and on the postnatal development of offspring reared by authentic and foster mothers. Subjects are inbred strains of mice with different levels of alcohol preference. Effects of ethanol on the mothers will be evaluated in terms of fertility and postpartum behavior. Effects on the offspring will be assessed in terms of growth, sexual maturation, and various behavioral and endocrine measures.

R01 AA00224.—Pathogenesis and treatment of alcohol-induced diseases ($78,500)

This is an interdisciplinary study of many facets of alcohol-induced liver injury. It includes investgiations of (1) pathogenesis of cirrhosis, (2) early phases of liver injury, (3) the role of dietary factors in pathogenesis of liver injury, (4) the changes of structure and function of gastric mucosa, (5) intestinal absorption of alcohol, (6) hematological endocrine abnormalities of alcohol-induced disease, and (7) prevention and treatment of these disorders. Human subjects are alcoholics admitted to a hospital for treatment (sex and age not specified.) Animal subjects are rates and monkeys.

R01 AA00380.—Women and alcohol ($60,000)

This study will address a number of questions that have been raised about women who are problem drinkers. Interviews with 200 women will take place as they enter treatment and again 1 year later. Approximately 100 sisters who do not have a problem with drinking will also be interviewed. The study women will be chosen from a variety of treatment settings in both urban and suburban areas; professional women and those from skid row or the homeless woman who is a problem drinker will also be interviewed. The study's objectives are to examine etiology, relationship of stress to drinking, effects and outcome of treatment.

R18 AA00457.—Community-reinforcement for treating alcoholic persons ($70,000)

A community-reinforcement approach to the treatment of alcoholic persons will be developed. This approach will extend laboratory-derived principles and nonalcoholism applications to the problem of alcoholism treatment. Vocational, family and social reinforcers will be arranged such that the alcoholic's new behavior patterns are incompatible with drinking. The comparison of the treatment modality with existing hospital procedure will use a matched-pairs design. Outcome measures to be employed are time spent (1) sober, (2) employed, (3) with family, (4) noninstitutionalized.

R18 AA00493.—Problem drinking of urban Indians--------------------- $46,708

This study will focus on the nature and extent of problem drinking of urbanized American Indians. The specific objectives are to (1) determine the quantity, frequency, context, and associated problems of Indian drinking in the city, (2) study the associations between Indian problem drinking and the demographic, social and psychological variables thought to be related to problem drinking, (3) compare Indian drinking problems with those of other urbanized ethnic groups (black, Mexican-American, and anglo) with similar socioeconomic backgrounds, (4) investigate variations in driking problems as a function of tribal affiliation, (5) determine changes in drinking behavior as a function of duration of stay in an urban environment. Data will be gathered through formal interviews.

R18 AA00498.—Clinical studies of alcohol use and abuse-------------($600,000)

This interdisciplinary research and education program will focus on clinical studies of alcoholism and alcohol abuse. Four major areas are delineated which encompass 15 individual projects:

I. STUDIES OF PSYCHOTHERAPY AND OUTCOME

A. Assessing psychotherapeutic and community environments.
B. Alcoholism: Future oriented and aversive therapies.
C. Group psychotherapy with alcoholics.
D. Children of alcoholic parents: Effects—intervention.
E. Comparative evaluation of alcohol treatment programs.

II. ADOLESCENT ALCOHOL PROBLEMS: DYNAMICS AND INTERVENTION

A. Alcohol research on adolescents.
B. Adolescents and alcoholism: Psychodynamics and intervention.
C. Alcohol and aggressivity.
D. Effects of ethanol on norms, conformity and status.

III. BIOLOGICAL CORRELATES OF ALCOHOLISM PROBLEMS: IMPLICATIONS FOR TREATMENT

A. Sleep indices and five hydroxytrytophan (5 HTP) effects in prognosis of alcoholism.
B. Brain responses and memory in alcoholics.
C. Biogenic amines and alcohol.
D. Alcoholism—genetic aspects.

IV. MULTIPLE-FUNCTION RESOURCES FACILITATING INTEGRATIVE STUDIES

A. Alcohol and California offenders.
B. Alcohol—violence clinic.

The goal of the program is to elucidate the complex interactions of psychosocial and biological processes believed to underlie alcoholism.

R01 AA00688.—Alcohol use during pregnancy and pregnancy outcome--- $64,782

The aim of this study is to determine if pregnancy complications or perinatal morbidity and mortality of infants is adversely affected by alcohol intake of the mother. The specific questions to be answered are whether prematurity rates, rates of stillbirths and abortions, neonatal mortality rates, rates of congenital defects are higher for drinking mothers than for nondrinking mothers. The four hospitals include a teaching hospital, two county hospitals and the Kaiser Health Plan Hospital serving a diverse population group. Analysis will be performed on many dependent variables taking into consideration the effect of such factors as parity, age, socioeconomic level, smoking, and nutritional history.

TREATMENT OF ALCOHOLISM UNDER "UNIFORM ALCOHOLISM AND INTOXICATION ACT"

Mr. MICHEL. You state on page 4 of your statement that implementation of the "Uniform Alcoholism and Intoxication Treatment Act" will remove alcoholism from the criminal justice system while in no way altering the provisions of a State's criminal law that protect public safety." In what ways, specifically, will alcoholics be treated under that act? Exactly what changes will be effected?

Dr. Chafetz. The "Uniform Alcoholism and Intoxication Treatment Act" is designed to provide States with the legal framework within which to approach alcoholism and public intoxication from a health care standpoint. It removes the legal sanctions in the criminal law which serve to treat citizens with alcoholism problems as criminals, to be arrested and incarcerated, merely because they are intoxicated or show signs of intoxication. The "Uniform Alcoholism and Intoxication Treatment Act" is a commitment to help these sick people instead of punishing them. The act stresses the voluntary treatment of alcoholics and provides that a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons be set up to include: Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital; inpatient treatment; intermediate treatment; and outpatient and followup treatment. The further development of effective health services—medical care, nursing care, counseling, intermediary care, home care, AA—should be an outgrowth of such a State commitment, and proof of the legitimacy of this approach under the law.

Mr. Michel. Do you differentiate between a problem drinker and an alcoholic? Is there a legal definition of an alcoholic? How would these individuals be identified for qualification under the "Uniform Alcoholism and Intoxication Treatment Act"?

Dr. Chafetz. Under section 2 of the "Uniform Alcoholism and Intoxication Treatment Act," an alcoholic individual is defined as "a person who habitually lacks self control as to the use of alcoholic beverages or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or whose social or economic function is substantially disrupted." This is not a strict medical definition, but an interpretation of such a definition for legal purposes, and is discussed as such under the comment paragraph appended to this section. The term "problem drinker" has a broad meaning not well suited to legal interpretation and generally implies something less severe than "alcoholic."

Under section 12 of this act, which pertains to treatment and services for intoxicated persons and those incapacitated by alcohol, the usual diagnostic service is accomplished by a licensed physician and serves to identify the individual whose medical, social, and psychological history would indicate the diagnosis of alcoholism, as opposed to the individual who has merely overindulged. It might be noted that the "Uniform Alcoholism and Intoxication Treatment Act" of at least one State provides that the individual who has merely overindulged will be warned on his inappropriate use of alcoholic beverages. In this respect, public intoxication may well be indicative of "problem drinking," a continuation of which would result in a condition medically diagnosible as alcoholism.

NUMBER OF DRUG ADDICTS IN THE UNITED STATES

Mr. Michel. We are certainly pleased to learn that our capacity has improved to the point that all addicts who want help can get it and that the waiting lists have been eliminated. However, could you give as the figures on the total number of drug addicts that there are estimated to be in the United States?

Dr. DuPont. The Drug Enforcement Agency's statistical report estimates that on June 30, 1973, there were a total of 612,000 narcotic addicts in the United States.

With respect to other drugs of abuse, the President's National Commission on Marihuana and Drug Abuse reported in 1972 that approximately 9 million persons aged 12 years and over are regular users of marihuana. The Commission's survey findings for number of youth and adults having had experience with other drugs of abuse show the following: barbiturates 6,250,000; amphetamines 7,950,000 hallucinogens 7,594,000.

Mr. Michel. How many individuals were actually treated during the past year? How does this compare with previous years?

Dr. DuPont. During fiscal year 1973, 93,188 clients were treated in 299 operational, National Institute on Drug Abuse-funded, community-based treatment programs; 68 operational programs treated 44,723 individuals during fiscal year 1972. Patients treated during fiscal year 1971 in operational programs totaled 19,953.

During fiscal year 1974, it is expected that 141,603 patients will be treated in 340 operational programs.

Mr. Michel. It is encouraging to note the apparent decrease in heroin addiction. What other drugs are currently heading the list of major problem drugs? Of the total number of drug addicts in the United States, how many are addicted to heroin and how many to other drugs?

Dr. DuPont. The abuse of marihuana, barbiturates, and cocaine currently head the list of major problem drugs of abuse other than heroin in the United States.

Another indication of the relationship among drugs of abuse can be found in the drugs abused by clients admitted to federally funded drug abuse treatment and rehabilitation programs during the month of December 1973. Of 7,224 patients admitted for treatment, 58 percent or 4,223 reported heroin as their primary drug of abuse. Of the remaining clients, the major primary drugs of abuse were reported as follows: harihuana 15 percent, barbiturates 6 percent, amphetamines 4 percent, and hallucinogens, 3 percent. Alcohol was reported in combination with other drugs of abuse by 4 percent of the clients.

OUTREACH PROGRAMS FOR ADDICTS

Mr. Michel. What kind of programs reach the addict and get him to come in for treatment? Have any such programs been instituted thus far?

Dr. DuPont. In order to reach drug abusers who have not volunteered for treatment under existing treatment programs, grant and contract projects supported by the National Institute on Drug Abuse are strengthening their outreach capability. Federal financial support is available for this purpose within the project budget. The type of outreach program which a project develops is dependent upon the size of the community, the referral services already present in the community, the role the project sees itself as playing in the overall drug abuse treatment efforts in the area, community attitudes and staff preferences. While the amount of money expended in outreach activities cannot be specifically identified because of its integral relationship to treatment, a few of the many approaches which projects use can be described.

An example of such efforts are "coffee house" programs located in areas of the city where drug trafficking is heaviest. Residential homes, or abandoned store buildings, are spartanly equipped with chairs, a table, coffee, and occasionally soft drinks or snacks which neighbors provide as a gesture of good will. Each outreach unit is staffed by an ex-addict who can recognize dealers, pushers, and users. This setting allows interaction between the staff member and the addict which will hopefully lead to treatment.

Another program utilizes "expediters" located in local industry. These expediters actively seek out the drug abuser and refer him into treatment. The treatment staff work closely with industries' staff in an attempt to help the patient to become an effective employee. In one industry the local union is being funded to provide its own treatment where management was reluctant to recognize the problem that drug abuse was creating in industry.

Another example is the treatment alternatives to street crime program which provides demonstration, screening, and referral services for the heroin dependent person shortly after arrest and offers the opportunity to enter a variety of treatment and rehabilitation programs. The cycle of drug-related crime, detention, release, and rearrest, with its attendent community costs, may therefore be interrupted and reversed.

Mr. Michel. Could you supply for the record statistics relating the rate of decrease in drug overdose deaths and in property crime for the major metropolitan areas in the country?

Dr. DuPont. The Drug Enforcement Agency reports that narcotic-related deaths in 23 major metropolitan areas have declined from 1,926 in 1971 to 1,781 in 1972, and to 1,157 for the first 9 months of 1973.

Concurrent with evidence of decline in the prevalence of heroin addiction, there is indirect evidence of a related decline in property crime in the Nation's major metropolitan areas. The reporting rate per 100,000 population reached a peak of 2,550 in 1971 whereas in 1972 the rate was 2,450. For one such metropolitan area, Washington, D.C., these figures dramatically illustrate the declining pattern: First, the decline in serious crime began late in 1969 when drug abuse treatment first became available, and has continued during the period of diminishing heroin abuse, prevalence, and availability; second, changes in the rates of property-related crime (those crimes traditionally associated with addicts) account for both the rise and decline of the crime rate in the last 10 years; third, when the monthly total of active patients in the city's comprehensive addiction treatment program is compared with the monthly property-related crime rate, there is a negative correlation; that is, as the rising numbers of addicts are brought into treatment, fewer and fewer crimes of the type associated with addiction were committed.

NARCOTIC ANTAGONISTS

Mr. Michel. I was very interested in your comments regarding narcotic antagonists. How long has naltrexone been undergoing human testing? How much longer do you anticipate it will be before you have some conclusive results?

Dr. DUPONT. It was first tested in man in 1972. The basic pharmacology has been fairly well characterized at this point, and we know that it is an orally effective, potent blocking agent which has a duration of action of 24 to 48 hours, depending on the dose given. The major question to be answered now is: Is it safe and effective in the treatment of large numbers of addicts in an outpatient setting? At the present time we have tested naltrexone for short periods in approximately 150 addicts. In the coming months we plan to expand it to several hundred addicts, and to administer the drug for longer periods of time in order to obtain a more definitive answer to the questions of safety and efficacy. We anticipate that these studies will be completed by sometime next year. If conditions warrant, a further study, collaborative and nationwide in scope, and aimed at giving more conclusive results will be started and hopefully concluded by the summer of 1976.

Mr. MICHEL. How many other narcotic antagonists are now being tested and with what results?

Dr. DUPONT. In our program we have approximately half a dozen antagonists in various stages of testing, ranging from early animal screening to very early human testing. As these drugs are proven to be safe after limited human testing, and more extensive toxicity studies, then expanded human testing will be intiated.

Mr. FLOOD. Mr. Conte.

REDUCTION OF RESEARCH AND MANPOWER PROGRAMS IN MASSACHUSETTS

Mr. CONTE. Thank you, Mr. Chairman. I have an overall comment first of all before I ask a few questions here.

I received a letter from the Massachusetts Association of Mental Health, and in part it said, "If this budget were adopted, it would destroy mental health services, research and manpower programs in Massachusetts as well as most of the States."

Then I have another letter from the University of Massachusetts which says in part "NIMH must undergo a reduction in force which will reduce its staff by 170 employees by June 30, 1974. This means that almost one out of five employees there will have to be 'RIFed.' The effect of all this would be quite catastrophic, not only for programs within the Commonwealth but also for programs throughout the Nation."

Dr. Egeberg, is this what these cuts are going to do?

Dr. EGEBERG. I don't think they are going to do that across the Nation. I would rather have Dr. Plaut speaking for the National Institute of Mental Health answer that if I may.

Dr. PLAUT. Mr. Conte, let me pick up the second part of your constituent's question first that has to do with the proposed reduction in force.

As Dr. Egeberg testified earlier in response to the chairman's question, that decision as it applies to this fiscal year has now been reversed. This means that 174 of the original reduction of 194 NIMH positions have been restored. The restoration is sufficient to avoid the involuntary separation of staff this fiscal year. That is in direct response to the second question.

With relation to the first question, the breakdown into various parts, research, training, and services—Dr. Egeberg has already dealt with these issues in a number of ways.

The thing I would like to reemphasize is that over the years the mental health training programs have demonstrated their effectiveness in increasing the number of mental health manpower, and it is now felt that further needs in this regard can be handled with funding from State and local sources.

Mr. CONTE. Even if the cut is restored, will job vacancies that come up be filled—up to the ceiling set by Congress for fiscal year 1974?

Dr. PLAUT. I prefer to have Dr. Egeberg or maybe some of his colleagues respond to that.

Dr. EGEBERG. Yes, they will.

ADMINISTRATIVE PROBLEMS IN OBLIGATING FUNDS

Mr. CONTE. Suppose Congress again appropriates funds for mental health categorical training programs. I am concerned about NIMH's ability to use those funds. What administrative, technical, and other problems will you have in using such funds if they are in an appropriation that comes out by September or October?

Dr. PLAUT. Mr. Conte, I think I understand the thrust of the question.

Usually, because of the time period involved, Mr. Conte, in providing consultation, in reviewing such grants, in sending them first to technical review committees and the National Advisory Mental Health Council, it takes a period of a number of months before that process is completed. I am fond of saying it takes about as long as a premature baby; that is, 8 months from the time somebody applies until he actually gets the money.

So the heart of your question was if there is no HEW appropriation until September or October, will that present some problems in managing these funds that are made available by the Congress, and the answer is yes, it will present some problems. And it will require some careful preparation on the Department's part, on Alcohol, Drug Abuse, and Mental Health Administration's part, and NIMH's part so that we can most effectively utilize those funds.

Mr. CONTE. Are you doing anything to prepare for that right now? It takes careful preparation. What preparation are you taking?

Dr. PLAUT. We have begun to initiate conversations with other levels of the Department so that as soon as possible we can have a resolution of these questions in order to inform potential applicants regarding what actions they might take knowing there is uncertainty regarding the final appropriation.

Mr. CONTE. What can we do to make sure our wishes get carried out in time for them to be worth something?

Dr. PLAUT. I am not sure I could answer that question, Mr. Conte.

Dr. EGEBERG. To some degree our ability to respond will depend on our final employment ceiling for fiscal year 1975. Processing grant applications does take a lot of time.

Mr. CONTE. It certainly does.

EARNING POTENTIAL OF TRAINEES

Mr. CONTE. Dr. Egeberg, high potential earnings are again mentioned as a reason for stopping Federal support of professional training. For the record, will you provide a breakdown of professional earning expectations for the groups covered by all three Institutes' training programs? Be sure to include as separate groups social workers and psychiatric nurses.

Dr. EGEBERG. Yes, sir. On the allied health professionals also?

Mr. CONTE. Yes.

[The information follows:]

Earnings Expectations for Professions, in Training Programs

The Alcohol, Drug Abuse, and Mental Health Administration does not have available information on the annual earnings of its former trainees. However, it is reasonable to assume that their earnings are comparable to national averages. Using various source data we have estimated the national average for the four mental health core disciplines as follows:

Psychiatrists—$47,500
Psychologists (Ph. D.)—$22,800
Social workers (M.S.W.)—$14,800
Nurses: B.A.—$9,500; M.A.—$14,000

In addition to the core disciplines, a significant amount of training funds are used to meet the needs for a wide range of mental health workers at various educational levels which are collectively known as the allied mental health professions. In this category, job titles are not well established, and it is not possible to provide average salaries. However, some of the general categories into which these workers are grouped, and the estimated salary ranges, are as follows:

Paraprofessional treatment workers, $6,000–$8,000
Counselors—$7,000–$9,000
Youth workers—$8,000–$9,000
Community workers—$7,000–$8,000

NIMH RESEARCH PROGRAMS

Mr. CONTE. The opening statement mentioned a study of the mental health research program. Since we now are faced with a budget with no funds for new research grants, I'd like a detailed statement in the record of that study's recommendations and an outline of them at this point.

Dr. EGEBERG. With respect to the grants?

Mr. CONTE. Yes, sir.

Dr. EGEBERG. We are working very hard on that at the moment, and it is better to do it in writing to you as soon as we get that finished.

[The information follows:]

Summary of the Report of the NIMH Research Task Force

INTRODUCTION

The Research Task Force of the National Institute of Mental Health has conducted a comprehensive review and analysis of research in mental health, particularly that supported by NIMH, over the last 25 years and, based on this analysis, has developed a set of recommendations for future directions.

The basic work of the task force was carried out by 10 study groups, totaling some 80 members, most of whom were active research scientists and close to one-third of whom came from outside NIMH. All the groups solicited the knowledge and advice of other scientists and research administrators—more than 200 in all, mainly from outside Government—in helping to compile and evaluate the results of a quarter century of research in every scientific field bearing upon mental health problems.

The studies and analyses, continuing for more than a year, resulted in a set of study group reports totaling 12,000 pages. The report of the task force as a whole presents the essence of this material in 18 chapters. It was written by the task force staff in cooperation with a coordinating committee that included the directors of NIMH operating divisions, the study group chairpersons, and a representative of the NIMH assembly of scientists. It was also reviewed at several stages by eminent scientists, research administrators, and others—all from outside NIMH—active in the mental health or allied fields.

BIOLOGICAL INFLUENCES ON BEHAVIOR

During the last quarter century, more has been learned about the brain than in all previous history. Thanks to research in behavioral genetics, brain development, neurophysiology, neurochemistry, neuropsychology, neuroendocrinology, and neuropharmacology—a significant part of it undertaken or supported by NIMH—we now have a substantial understanding of some of the biological processes affecting the state of our mental health and are making steady progress toward the understanding of others.

Of the many advances by basic science since the founding of the Institute in 1948, two are particularly significant. One is the discovery that information is transmitted through the central nervous system by the release at nerve cell terminals of brain chemicals called neurotransmitters. The discovery of neurotransmitters led directly to our understanding of one of the mechanisms of action of the drugs used to treat the major psychoses, schizophrenia, and depression. These drugs appear either to facilitate or block the action of neurotransmitters.

The second major advance is the accumulating evidence that heredity plays an important role in abnormal behavior—certainly in schizophrenia and depression, possibly in alcoholism and some forms of neurosis. As in some cases of mental retardation, further research may make it possible to correct for the still unknown biochemical abnormalities through which the genetic factor is expressed. Taken together, these findings open such possibilities as: (1) more effective pharmacological treatment of mental illness; (2) blood or urine tests for the presence of a mental disease or of a predisposition to it; (3) treatment for the prevention of mental illness.

OTHER CLUES TO THE NATURE OF MENTAL ILLNESS

Twenty-five years ago, psychology and psychoanalysis provided virtually the only frame of reference for the study of mental illness. The situation today is quite different. Thanks to the fundamental biological discoveries discussed above, the biological sciences constitute a powerful new frame of reference for research in the major mental disorders. In this short time period, these disciplines have contributed testable biological hypotheses, significant and replicable findings, and effective forms of treatment.

During this quarter century, the psychological and social sciences have also made highly significant findings. As one notable example, numerous studies have shown an especially high rate of schizophrenia among the people at the lowest socioeconomic levels of large cities. This is one of the great mysteries of research on mental disorders. Since no single explanation has been proved valid, a pattern of factors is probably responsible. Current thinking takes account of three likely factors: (1) a predisposition to schizophrenia, almost certainly genetic; (2) extreme social and psychological stress generated by the conditions of life in the poorest neighborhoods; and (3) an impaired capacity to deal with stress, also attributable to the constricted conditions of life among the poor.

Some years ago, studies indicated that certain family processes, including disordered parental communication patterns, contributed to mental illness and behavior disorders. Subsequent research suggests that disturbances of family processes may be a result of abnormal behavior rather than a cause of it. For a definite answer, NIMH supports a number of longitudinal studies, which begin before a child is born and for some years take note of the principal circumstances of his or her life. Such research should eventually explain what elements are needed to trigger mental illness even in those carrying a predisposition to it. Preliminary findings suggest that one element is physiological stress before or around the time of birth.

RESEARCH ON TREATMENT

NIMH has supported almost every major researcher in the field of psychotherapy and behavioral intervention. The Institute's intramural research program has contributed importantly to the development of family therapy and of milieu or therapeutic environment treatment.

Although NIMH played no significant role in the discovery of the first psychotropic drugs, it pioneered in assessing their effectiveness and explaining their action, and it established a nationwide network of early clinical drug evaluation units to search for new pharmacological treatments.

PSYCHOTHERAPY

In general, the classical conceptions of psychoanalysis and psychodynamic therapy have proved difficult to subject to scientific study. Though they continue to have a major influence on all forms of psychotherapy, the number of NIMH-supported research projects in this area, as compared to those in other treatment areas, has declined steadily over the years. Some of the findings from studies of the outcome of psychotherapy can be summarized as follows:

Most forms of psychotherapy are effective with about two-thirds of nonpsychotic patients. Whether one form of psychotherapy is superior to another has yet to be convincingly demonstrated.

Patients who benefit from psychotherapy are highly motivated, experience acute discomfort, anticipate help from treatment, are intelligent and reasonably well educated, have achieved some social success, are reflective, and are able to experience and express emotion.

Characteristics of the effective therapist remain unclear, but there is no research support for the currently popular belief that the effective therapist need only be genuine, empathic, and warm.

BEHAVIOR THERAPY

The philosophy and techniques of behavior therapy were derived principally from laboratory research on conditioning simple responses, primarily in animals. Through operant conditioning, the basis for most behavior therapy, the organism acquires a skill because he is reinforced, or rewarded, for doing so. The reinforcement may be food for a rat or a pigeon, candy for an autistic child, points for a trip home for a hospitalized mental patient, or, in the classroom, simply praise and the satisfaction of accomplishment. Such therapy has been frequently and successfully applied in institutions to alter the behavior of psychotic adults and autistic children. NIMH support of research on behavior therapy now exceeds that of research on psychotherapy.

SOMATIC THERAPIES

These are chemical and physical interventions that affect the brain and produce changes in thought, mood, and behavior. The Institute's support of research on such approaches, particularly chemotherapy, exceeds that for all other types of therapy combined. These investigations show that psychotropic drugs do not cure schizophrenia and the serious depressive illnesses, but that they do appear to interrupt the psychotic episode and to ameliorate symptoms. Used as prophylactics, they can also reduce or prevent the recurrence of symptoms. Consequently, the focus of treatment has shifted from terminating psychotic episodes to attempting to maintain the individual as a functioning member of the community.

From the clinical standpoint, the single most dramatic and far-reaching event since the Institute's inception was probably the discovery that a chemical compound, chlorpromazine, is useful in the treatment of schizophrenia. Almost equally important was the discovery that other chemicals—including, in recent years, lithium for combating manic-depressive psychosis—could be used to treat and prevent depression. Less dramatic but also of far-reaching importance was the discovery—attributable in large part to research and demonstrations supported by NIMH and carried out with its guidance—that mental illness could be treated in the community. It was these research and demonstration projects that laid the foundation for the national program of community mental health centers.

Other research on treatment has shown that: (a) controlled electroconvulsive therapy is the most effective and most rapid-acting treatment for the relief of symptoms of the depressed states of manic-depressive psychosis and involutional melancholia, and (b) the claims for megavitamin or orthomolecular therapy are not supported by research.

OTHER SUBJECTS

The Research Task Force report also describes advances (1) in research on alcoholism and on drug addiction, two areas for which the responsibility was recently transferred to institutes independent of NIMH; (2) on social problems—such as crime and delinquency—other than mental illness and the addictive disorders; (3) on child mental health and on aging; and (4) on more effective ways of delivering mental health services and fostering the dissemination and use of research findings.

SOME MAJOR RECOMMENDATIONS

In spite of the substantial progress in every mental health research area since the Institute's founding, the task force uncovered a number of critical needs. To meet these, the report incorporates specific suggestions for research in each area and also puts forward a number of general recommendations, of which the following are representative:

1. Because basic research generates new knowledge about the myriad of complex processes governing human behavior—knowledge necessary for alleviating mental illness and strengthening mental health—the trend in NIMH toward reducing the support of basic research should be halted and reversed. In neurobiology, as one example, the Institute should increase its funding of research in behavioral and biochemical genetics and in other currently undersupported areas. As in the rest of medicine, clinical researchers in mental illness can only apply the findings of scientists working at more basic levels.
2. The Institute should strongly support clinical—as well as basic—investigation of biological factors in schizophrenia and depression. For example, studies of twins and of adopted children must be supported in order to disentangle the genetic from the psychosocial determinants of these psychoses. In three other groups of disorders—the organic psychoses, the psychoneuroses, and psychosomatic illness—research is by no means commensurate with their consequences to public health and should be increased.
3. The Institute should strongly support research designed to reveal, by studies over a period of years: (a) the antecedents of mental disorders in children, and (b) the factors that make some children even in high-risk groups apparently invulnerable to such disorders.
4. In treatment research, NIMH should—among other undertakings—increase research on the relative effectiveness of professional, paraprofessional, and nonprofessional therapists; on the early detection of emotional problems, with special emphasis on those of children; on the effect of combined pharmacotherapy and psychosocial therapies on specified patient populations; and on the long-range adjustment of drug-treated schizophrenic patients.
5. The Institute should continue the development and testing of various behavioral therapy techniques, including biofeedback, self-control measures, and procedures for training parents and others to act as behavioral therapists. NIMH should also establish a standardized treatment assessment program to identify and evaluate the mechanisms and the effects of newly emerging therapies, as a protection for prospective patients.
6. In supporting research on social problems, the Institute should emphasize an approach that takes into account not just single determinants, but patternings of several main groups of variables—social, psychological, and biological.
7. The Institute should use every means at its command to obtain: (a) reliable data on the incidence and prevalence of mental disorders among the general public, and (b) more nearly accurate ways of measuring the need for and the effectiveness of specific mental health services in a given population.

Mr. CONTE. What kind of a researcher, generally, uses "small grants"?

Dr. EGEBERG. People who have a new idea or one testing out a new program. I think Dr. Plaut might like to answer that.

Dr. PLAUT. They use them for two types of researchers. The first would be young researchers who are beginning in their careers and who have not yet had the background and experience to develop large-scale projects. So in that sense it is a cutting edge.

Second, it is specifically intended for exploratory research so that one can have a minimum investment to see whether the larger investment at a subsequent time is worth the effort. And this program just recently celebrated a major anniversary, its 100th consecutive review meeting, getting together some of the investigators recently supported in this program and many of them have now made important breakthroughs and are highly respected in their professions.

APPLICATION FOR SMALL GRANTS

Mr. CONTE. Could you tell me how many applications for small grants you get each year and how many get approved as scientifically worth while?

Dr. PLAUT. I will be glad to provide that for the record.

[The information follows:]

SMALL GRANTS

The actual number of small grant projects reviewed fluctuates from year to year. From fiscal year 1972 to 1974, an average of 560 projects was reviewed in each year. About 41 percent were approved by the Small Grant Review Committee.

Mr. CONTE. The small grant budget is down 25 percent. What kind of research will be most affected by this cut?

Dr. PLAUT. Some of the priorities for mental health research are in the areas of depression, in the area of schizophrenia, in the area of the basic psychobiology of mental illness. Those would be the areas with the highest priority.

It might well be necessary to fund a smaller proportion of such grants and to give lower priority to some of the other important areas having to do with social problems, having to do with delinquency and so forth. The priorities would be for the basic mental illnesses, schizophrenia, depression, and the basic physiological and biological aspects of human behavior generally.

RESEARCH CAREER PROGRAM

Mr. CONTE. The justification doesn't specifically say so, but it looks as if the research career program is also being phased out. Is that so?

Dr. PLAUT. The reduction in the research career program reflects in part awareness that this program has been highly successful and an expectation that in the future additional support for such young investigators will be forthcoming from universities and other training institutions.

Mr. CONTE. You are pretty clever. It is being phased out?

Dr. PLAUT. No, sir. It will continue but at a reduced funding level.

Mr. CONTE. You would make a good lawyer.

How many psychiatrists are in full-time research now?

Dr. PLAUT. I believe I would have to provide this.

[The information follows:]

PSYCHIATRISTS IN FULL-TIME RESEARCH

A 1970 survey of psychiatrists indicated that 310 spent 40 percent or more of their time engaged in research activities. This represented 2.4 percent of those responding. Assuming this to be a representative survey, it may be inferred that there are 350 to 400 psychiatrists in the United States who are engaged in research activities for a substantial portion of their time (40 percent or more). The National Institute of Mental Health has supported many of these individuals through its research and training programs. The research career development program has supported 121 psychiatrists throughout its history, or about 30 to 35 percent of the total number of psychiatrists in research. Additionally, the NIMH research grant program supports about 175 projects headed by other psychiatrists.

Mr. CONTE. How many of those came out of your research career program?

Dr. PLAUT. A very large proportion of the senior research psychiatrists in American universities and medical schools received not only their initial residency training but some of their specialized training through the various research training programs of the National Institute of Mental Health.

Mr. CONTE. Without the program what do you think the prospects are for bringing in more researchers and what are the problems?

Dr. PLAUT. To the extent that the society sees the value of basic biological, psychological, and sociological research in the mental health field young men and women will be attracted into this field, with the prospect of having careers in this field.

REGIONAL OFFICE TECHNICAL ASSISTANCE TO CMHC'S GRANTEES

Mr. CONTE. Putting aside the issue of extension of community mental health centers, what kind of help can NIMH provide local and State groups for their programs if they get funds for centers from other sources?

And is that consultation and technical assistance given by regional offices or your central staff?

Dr. EGEBERG. Both.

Mr. CONTE. Both?

Dr. EGEBERG. Yes, sir. We are, however, trying to increase the number of programs administered through the regional offices. Right now most programs are still administered from the central office.

Could I go back to the last question you asked about research for just a second?

Mr. CONTE. Certainly.

Dr. EGEBERG. We have $3.2 million, which I believe is primarily in mental health, for stipends for people who already have a doctor's degree. These will be research fellowship awards. They are specifically targeted at program areas where it is felt that we have a shortage of trained personnel in a particular research field. So this is a new effort to focus on people who have already had a lot of training and to get them into areas where we feel they are needed.

Mr. CONTE. You have $3.2 million for that?

Dr. EGEBERG. $3.2 million.

CHILD MENTAL HEALTH

Mr. CONTE. Child mental health has been your special concern for a good many years. What do you think NIMH's greatest contribution in this area has been?

Dr. PLAUT. I think the contribution has been at two levels, Mr. Conte. One is identification of this as a national priority by the Federal mental health program has been a flag which has indicated to communities, to training institutes and the community mental health centers that for too long the needs of young people have been in the back and have not really been dealt with. In a sense that is a symbolic level and that hasn't been without its importance.

Mr. CONTE. Is that also the greatest need?

Dr. PLAUT. No, it is not the greatest need.

Mr. CONTE. What is the greatest need?

Dr. PLAUT. The greatest need is to get a commitment of personnel at all levels of government in training institutions, in community mental health centers to overcome the long-term neglect, including child abuse, of the need of young persons.

We talk about this being a youth-oriented society and a society that cares about its children, but there are many evidences that we still do not care about children and young people to the extent that we should.

Let me respond to the other part of my initial remarks.

Part F of the Community Mental Health Centers Act, which was a recognition by the Congress that even in the comprehensive community health centers we were not paying enough attention to the needs of children, is a second very important element.

Third, in relation to research grants and training grants we estimate that close to one-sixth, 16 or 17 percent of all of the funds spent by the National Institute of Mental Health are directly related to the mental health and other needs of young persons.

DEPRESSION

Mr. CONTE. What does a psychiatrist mean by "depression" as opposed to the way the ordinary person uses the term?

Dr. PLAUT. Let me respond in part here and then in more detail after a consultation with Dr. Brown and others for the record if I may.

Mr. CONTE. Certainly.

Dr. PLAUT. A psychiatrist means by "depression" the phenomena ranging from the transitory frequent experience of all human beings, namely a feeling of inadequacy, feeling of lack of worth, inability to mobilize energy to do our day-to-day tasks, ranging to very severe disorders which totally incapacitate such as the depressive phases of manic depressive illness.

Depression is the second most frequent cause of admissions to State and county hospitals and to the psychiatric wards of general hospitals, exceeded only by schizophrenia. An increasingly large number of patient care episodes in outpatient facilities are for patients that have depression. Men as well as women.

Dr. EGEBERG. Why don't you mention lithium?

Dr. PLAUT. What Dr. Egeberg has reminded me of here is one of the most important scientific breakthroughs in the area of treatment of severe depressions, particularly depressions associated with the most serious kind of depressive illness, namely, treatment both in the acute phases and preventive, by lithium carbonate of depressive illness and disorders. This has been found to be extremely useful, and the Food and Drug Administration is just in the process of certifying this medication so that it can be more broadly used. With your permission we will supply a detailed report on that.

Mr. CONTE. Also if you can supply for the record any other research on the causes and treatment of depression.

Dr. PLAUT. It will be a pleasure.

[The information follows:]

DEPRESSION

DEFINITION

The concept of depression has been used to describe a normal emotional state of varying degrees of intensity, a personality style, a symptom and a set of identifiable disorders involving several distinct patterns of symptomatology. As a mood, depression is part of normal human living. Feelings of sadness, disappointment, and frustration are within the vicissitudes of the normal human condition. The line between normal and "clinical depression" is not clearly demarcated, but when the state goes beyond the normal emotion of sadness and begins to have major effects on behavior, thinking, and physical functioning, we begin to think of the condition as pathological. As a symptom, pathological depression often occurs in association with other psychiatric and medical illnesses and may pose difficult diagnostic problems.

In current clinical practice, diagnosis of depression delineates one or more syndromes in which there are abnormal, persistent emotional changes associated with feelings of worthlessness, guilt, helplessness; anxiety, crying, suicidal tendencies; loss of interest in working and other activities; impaired capacity to perform everyday social functions and accompanied by such physical alterations as anorexia, weight change, psychomotor retardation, headache, and other bodily complaints. Even to the untrained observer, most depressive states are clearly seen as pathological by virtue of their intensity, persistence, and other interference with normal social and physiological functioning. All these symptoms seldom occur in any individual patient. Varying combinations are observed. Traditionally, there have been many different theories concerning causation. Several systems of diagnosis reflecting these differences are currently in use by psychiatrists and other mental health professionals.

PSYCHOLOGICAL APPROACHES

New concepts of the underlying psychological basis for depression are currently being investigated at both the animal and human levels. One approach seeks to create an animal model of helplessness—thought to be one major fac of depression in man. Another studies the clinical treatment of adolescents in crisis of depression and suicide. Finally, a psychological approach based upon the principiles of behavior modification seeks to design a treatment procedure for the milder forms of clinical depression. A review of promising theories and paths in research was conducted through an NIMH-sponsored conference to encourage new directions and make recommendations for the future.

LITHIUM THERAPY

Lithium carbonate, a simple chemical salt previously used as a table salt substitute was discovered to have psychoactive properties in 1949. Following a long series of clinical trials in the United States and abroad, including multihospital collaborative studies carried out jointly by the VA and NIMH, it has been conclusively shown that lithium carbonate: (1) is an effective agent for the acute treatment of the manic phase of manic-depressive psychosis; (2) when given on a long-term maintenance basis, markedly reduces the recurrence of affected episodes in individuals diagnosed as having manic-depressive illness; (3) is ineffective in controlling some forms of recurrent depressive illness.

The effect of the drug is quite specific in controlling the symptoms of these disorders and when blood levels are carefully monitored, side effects are minimal. The specificity of this drug and the studies of its mechanism of action have advanced our knowledge of the mood disorders an encourage the use of various other psychoactive drugs to prevent relapse in other major mental disorders. Individuals previously known to be at risk for repeated recurrences of major mental disorders now have an effective agent to protect them against these crippling episodes.

SPECIAL YOUTH ALCOHOLISM PROGRAMS

Mr. CONTE. You mentioned in answer to the chairman's question, Dr. Chafetz, that alcoholism among young people was increasing and alcohol seems to be replacing heroin use. Does the Alcohol Institute have any special programs for this age group?

Dr. CHAFETZ. We have not targeted in specifically to the young age group because this information is just really becoming available to us. We have found, however, in some of our specialized programs, for example the drinking driver program associated with the alcohol safety action programs of the Department of Transportation, that many of the persons that are being picked up for "drinking while intoxicated" are young people. Second, in the Indian alcoholism programs, we are finding a lot of young people coming into the programs.

We have, of course, developed a national education prevention program which is targeted specifically, and hopefully most fruitfully, at the young people of this country. We have not, however, tried to set up specific treatment programs for young people per se.

Mr. CONTE. It might be an area that has tremendous potential.

Dr. CHAFETZ. I think you are absolutely right, Mr. Conte. You may not know this, but before I became a bureaucrat I was a Massachusettsan. One of the studies that we did in the Cambridge Court Clinic was a study to find first-arrest offenders with alcohol-related problems. When we proposed this study we thought we would get an age group of 18 to 20, and we ended up with a study group between the ages of 14 and 16.

I would say to you that from the findings of that study two things are important to our statement here.

One is that these young people are not just having troubles with alcohol alone, they are having other problems, but that society turns its deaf ear to them and they resort to alcoholism. Second, that their needs do not have to be taken care of by specialized alcoholism treatments. They ought to be part of the total health treatment delivery system.

EFFECTS OF MARIHUANA ON HEALTH

Mr. CONTE. In answer to the chairman's question on drugs, Dr. DuPont, on the effect of marihuana on the body, you didn't give a specific answer. There are some reports that continual use of marihuana has some effect on the body's immunity to disease generally. Have you gone into that?

Dr. DUPONT. This belief stems from a recent study done at Columbia University by Dr. Nahas. One of the problems in drug abuse findings of course is the sudden emergence of a new finding with rapid dissemination due to the media. It takes a little while for the scientific community to evaluate these initial findings carefully. This finding is one of a number of problems we are looking at more carefully.

In the last year there have been new reports of chromosomal breakage resulting from marihuana usage. This has also caused us considerable concern and we are carrying out further studies to assess its validity. Dr. Nahas' study was not a clinical but a laboratory study. We have no reports indicating that the incidence of infection or disease is influenced by marihuana use.

MENTAL HEALTH PROBLEMS ASSOCIATED WITH THE ENERGY CRISIS

Mr. CONTE. A few months ago HEW predicted mental health problems would increase because of the economic and energy problems. Do you have any early readings on how that prediction is being borne out?

Dr. EGEBERG. No, but we have evidence in the past where there has been a crisis in which people are deprived or made anxious and the number of admissions to the psychiatric institutions have increased.

Dr. Plaut, have they increased recently in our mental health centers?

Dr. PLAUT. Getting hard data in this short time period is very, very difficult. We have some impressions, and they go in two directions.

There are fascinating anecdotes relating to difficulty of patients getting treatment because of transportation problems associated with the absence of gasoline and the lack of alternative means of transportation.

On the other hand there is no across-the-board evidence that the number of patients either seeking or utilizing treatment have gone up or down.

In relation to some of the more subtle aspects of the mental health impact, the participation jointly, for example, in a gasoline line, can go two ways. Everybody has a common enemy that they are angry at and that builds a sense of solidarity, and we have all seen reports in the press and media about the way in which people gang up on somebody who sneaks into the line. It is a funny kind of in-group developing among strangers which is not always characteristic of the American society.

We are continuing to gather information on this. The press has been very interested.

One of the other aspects we are asking a number of our scientists to look at is the experimental evidence from the Quartermaster Corps and other sources as to what the impact would be on psychological functioning of normal persons, as well as patients, in an environment where instead of the temperature being 72 degrees it is 78 or 80 degrees. We are talking about the possible obverse of cold homes, talking about hot offices and hot homes this summer. This is something we have asked a number of our specialists, grantees, to look at and see whether they can make some predictions as to under what circumstances this warmer environment would cause some additional problems.

I believe Dr. Chafetz has some observations to add here.

Dr. CHAFETZ. Mr. Conte, we already have data in those areas most significantly hit by gasoline shortages and the sale of alcoholic beverages has shot up.

Mr. CONTE. On the other hand, life insurance companies report that the mortality rate is down. One of the reasons may be that lower home temperatures are healthier, people aren't getting as many colds going in and out of the house. It is a very encouraging sign.

Dr. CHAFETZ. The mortality rate has also gone down on the highways as a result of lowering the speed limit and the fact there is less usage of mileage. The alcohol industry has felt this is proof alcohol hasn't been as related to highway deaths as we have stated it to be, but that is open to question.

ADAMHA INFORMATION CLEARINGHOUSE

Mr. CONTE. There seem to be three information clearinghouse operations in the administration, one in drugs, one in alcohol, and one in mental health. My question is: Are they integrated in some way, for example, do they share computer facilities and personnel?

Dr. EGEBERG. They are integrated and they do share computer facilities.

They have remained independent so far but we are studying the possibility of integrating them to a greater degree. If you take the people interested in alcoholism and add them to a list of those interested in drug abuse and in mental health, you get a rather large list of which two-thirds aren't particularly interested in the other subject. So we feel it is a good idea to keep them apart for the present until we can find out how much overlapping there might be.

We have no sharing of personnel but we are having discussions to find out whether we are overlapping in any way that could make us inefficient.

INTERRELATIONSHIP OF DRUG AND ALCOHOLIC ADDICTION

Mr. CONTE. Are studies of addiction—whether of drugs or alcoholism—interrelated?

Dr. EGEBERG. Drugs and alcohol have become more interrelated in the last year or two. I imagine that within the next 6 or 8 months an interrelationship of a much greater degree will occur almost of necessity.

Mr. CONTE. Thank you very much. All of you have made a very fine presentation.

ALCOHOLISM AMONG YOUTH

Mr. CASEY. In response to Mr. Conte's question about the use of alcohol, you have given us a lot of statistics with reference to ages 14 to 16. If I recall correctly, he asked what you are doing about alcoholism among the youth. You said you are making the public more aware of it and trying to get more young alcoholics into the clinics. Are you making any changes in your programs?

Dr. CHAFETZ. Mr. Casey, the fundamental way that this is being respond to of course is through our Youth Education Branch in the Division of Prevention. But the outcome is being reflected in other ways.

For example, if I were to take the city of Los Angeles, 5 years ago they had no A.A. groups that were made up of preteenagers. Two years ago, after the institute had been created and this educational thrust had begun, they had 12, and last year they reported the number had shot up to 25. That is just in one metropolis.

Second, we are finding a shift in the average age of patients coming into our alcoholism treatment facilities. It is going down considerably.

As I said earlier to Mr. Flood, I think the issue of the alcoholism thrust in this country after almost 200 years of neglect and 3 years of concerted Federal effort has a long way to go, and this is one of the areas that we will have to give added attention.

Mr. CASEY. I will repeat my question. What are we doing about the youngsters? You tell us what A.A. is doing. Is that the private organization or have you had some input into Los Angeles creating these A.A. units?

Dr. CHAFETZ. I am sorry, sir. It is our contention that not everything that happens in alcoholism can, should, or will be able to be just the outcome of Federal efforts. A.A., as you probably know, is a private voluntary effort on behalf of alcoholic people.

Mr. CASEY. I know all of that. I want to know what you are doing. What do we have this appropriation up here for if it isn't to attack problems like alcoholism, drug abuse with a Federal effort and try to stimulate private efforts?

Dr. CHAFETZ. The programs that we fund, Mr. Casey, are the ones that get these programs like A.A. to have more clients. For example, A.A., before the NIAAA was established, had a patient roll of 535,000. In the 2 years since the start of the Federal effort, they report that their rolls have jumped to 750,000.

Mr. CASEY. That is what I want to know.

FEDERAL EFFORTS TO STUDY ALCOHOLISM AMONG YOUTH

Dr. CHAFETZ. There are other things that just occur to me we have not mentioned to you, and I apologize for that.

One, we have recently undertaken the largest survey of teenage drinking practices and problems that the country has ever had, and hope to have the results included in the report to Congress on alcohol and health.

Second, we have given a contract to the parent-teachers' association for the purpose of developing educational efforts in the schools so that people who have problems can get to treatment facilities.

Third, we have a contract with the educational commission of the States which will provide another way to prevent alcoholism among young people.

We also have a very active program with the JayCees organization which attempts to mobilize young people who are getting into trouble with alcohol to get to the treatment facilities.

Mr. CASEY. In other words, you do have something going on in the schools?

Dr. CHAFETZ. A tremendous amount, sir. I think we are doing more. I guess every once in a while I get humble and I apologize.

FEDERAL ALCOHOL EDUCATION PROGRAMS

Mr. CASEY. You sometimes have to brag a little bit here when you are after money.

The Office of Education is strong on counseling and providing funds for school districts to help employ capable personnel so that youngsters will know what direction they are going to go in their education—to see that they are taking the right courses, and to try to keep them in school. Do you have anything of that nature going on?

Dr. CHAFETZ. Yes, sir, we have contracts and a very close working relationship with the Office of Education, with a variety of agencies in the Federal Government so that we can target in on their activities. We are very actively engaged also with the SRS. We have given them some money.

Mr. CASEY. What is the SRS?

Dr. CHAFETZ. Social Rehabilitation Service in the Department of Health, Education, and Welfare. And we also have gone across to the Department of Labor. We have a number of interagency activities to do just what you suggested.

Mr. CASEY. I think that is what you need to tell us. If you just say, "We are making surveys and finding this," you tell us only that we have the problem. A survey does tell you how large the problem is, but I think you ought to do more than that. If you want to add further to the record later, feel free to do so.

Dr. CHAFETZ. Thank you, sir.

Mr. CASEY. This is a problem I think that concerns us all.

[The information follows:]

YOUTH EDUCATION PROGRAM

While prevention programs may not have the immediate payoff that is realized through medical treatment and other health and social services, it must be understood that prevention is the only effective way to ultimately remove the spiraling human costs of alcoholism from our culture. To be successful, prevention efforts must focus first of all on our Nation's youth. Recent data indicate that young people are drinking sooner, more often; and in greater quantities than in the past. For this reason it is critical that the Nation's youth learn to handle alcohol more responsibly than today's adults. In order to accomplish the goal of preventing alcohol abuse and alcoholism, among this Nation's youth, the Youth Education Branch is carrying on the following activities:

1. Efforts are being mounted toward prevention efforts both in and out of school which are targeted toward youth who have not yet established drinking patterns and toward youth who have already begun to drink alcoholic beverages. These programs will include all cultural, racial, and ethnic backgrounds. A grant has been awarded to the Philadelphia Mental Health/Mental Retardation Associates, Inc. in the amount of $124,727. The overall goal of this program is to minimize the occurrence of alcohol abuse in its various forms and to encourage the overall psychological development of the youths participating in the program. The project is designed to capitalize upon and use the natural modeling processes already existing in the youth culture of the community. The students themselves will have an integral role in carrying out this project.

2. Collaborative studies with the NIDA are being planned to design innovative instructional materials and teacher training strategies designed to provide viable and relevant learning experiences for students in the use and misuse of alcohol. For example, the National Institute on Alcohol Abuse and Alcoholism entered into an interagency agreement with the Office of Education amounting to a total of $1 million for the development of a series of films for elementary and secondary school youths. These films will be completed in fiscal year 1974 and distributed in fiscal year's 1974 and 1975. The University of Michigan School of Public Health, has received a grant in the amount of $23,883 to develop a series of trigger films. The purpose of these is to provide a catalyst for group discussion in a variety of settings. Finally, the National Clearinghouse for Alcohol Information is developing curriculums packages for teachers of grades K–3, 4–6, and secondary levels. These packages will be designed to quickly meet the specific needs of teachers writing to the clearinghouse and will integrate the topic of alcohol into a wide variety of subjects normally taught by these teachers.

3. Finally, the NIAAA is attempting, whenever possible, to include educational components for the parents of youthful target groups. Specific programs will be designed for new parents in order to sensitize them to the issues of alcohol education and their influence as role models upon their children.

A grant has been awarded to the Akron, Ohio, YMCA in the amount of $90,203 to initiate an alcohol abuse prevention program directed toward elementary students in the 4th, 5th, and 6th grades (ages 9 through 11). The program includes extensive parent involvement through such mechanisms as communication skills workshops, video tape replays, etc. Emphasis in this project is on the development of life goals through the clarification of values, attitudes, and decisionmaking. During the second year this program will be expanded to 30 additional YMCA's throughout the country.

The National Institute on Alcohol Abuse and Alcoholism entered into a reimbursement agreement with the Center for Disease Control to support a prevention and education program under the auspices of the National Congress of Parents and Teachers Association. The project represents a unique effort to sensitize parents and teachers to the fact that alcohol is a drug and that adults when using the drug (either responsibly or irresponsibly) serve as models for their children.

Finally, the National Center for Alcohol Education is developing a curriculum pacakage to meet the needs of parents of young children. This package is currently in the needs assessment stage.

Mr. CASEY. Mr. Michel.

STAFF COSTS AT CMHC'S

Mr. MICHEL. Thank you, Mr. Chairman.

Doctor, under community mental health centers, we have one out in our area and some of the folks out there now, I understand, are getting a beefed-up request for additional money. While I would like to be as helpful as I can, I am getting some reverberations from some of the people actively engaged in this thing that too much money is being allocated to staff, rather than real programs. I wonder if this is a trouble throughout the country.

Do we find people taking advantage of this real easy Federal money to just keep piling on one additional staff person after another so it is getting topheavy and very little left for actual program implementation?

Dr. EGEBERG. I would rather have Dr. Plaut answer it. I did say earlier, sir, when it comes to supporting these community mental health centers, on the average we are supplying about 30 percent of a center's support costs. If there is excess staff it may have some State or other input.

Dr. PLAUT. In a major new effort such as the community mental health centers program there are inevitably going to be some growing pains of the kind you referred to. Over the last 2 or 3 years there have been a number of groups that have looked at the community mental health centers program, ranging from your own GAO to some of Mr. Nader's operations.

It is very interesting that a significant proportion of the criticism aimed at this program from Mr. Nader was based on documents that had been prepared by NIMH staff. So we have been aware there have been problems with this program.

I know in one of the Midwestern States there has been very specific concern with the extent to which staff was being added and it might not be the best use of the moneys. I would say on a national basis, the salaries in these community mental health centers are barely competitive with the other settings in which people might be working, that the response of the community and the citizens boards to the dedication and the work the center staff, while not universally favorable, it has generally been favorable.

There is no question there have been cases where this hasn't been policed as well as it might have been by the Federal Government or by the State mental health authorities that are increasingly moving into standards setting in regard to these facilities.

We have a number of contracts outstanding which are attempting to increase the capability of the States to set such standards and to identify weaknesses of the kind you describe.

Dr. EGEBERG. I have some statistics here, sir. Our staffing grants support only a portion of the costs for professional or paraprofessional personnel.

Sixty-five percent of a center's budget in 1972 went for salaries; 66 percent in 1971; and 66 percent in 1970. Twenty-seven percent goes for operating expenditures.

SALARY LEVELS OF STAFF OPERATING CMHC'S

Mr. MICHEL. Are those salary levels pretty uniform throughout the country or is there a wide disparity there?

Dr. PLAUT. There is a very wide disparity.

Mr. MICHEL. Is that good?

Dr. PLAUT. I think it reflects the diversity and the heterogeneity, Mr. Michel, of this country.

Mr. MICHEL. I don't mean to imply by my question that I think it ought to be uniform, because like postmaster's salary in the old days, if you got down South it was one of the best jobs in the community and up in the Northern cities they were going begging. There is still a difference to some degree around the country. I would be the last one to say because of such and such a salary in Washington, D.C., it has to be that in Peoria or someplace.

Go ahead.

Dr. PLAUT. As you well know from your own experience in your own district these community mental health centers are not Federally run facilities. They are locally run State or nonprofit local organizations. And because of the marketplace economics, pay for professionals and for the nonprofessional mental health workers will vary from State to State from urban to regional areas, the cost of living and other expenses will be different. I very strongly agree with you that it would be inappropriate for the Federal Government to try to force a single standard in that regard.

It is true that one of the difficulties in Appalachia or some rural poorer parts of your State is recruiting people because some of the other advantages which we have in the metropolitan areas are not available to people. So you have to pay them more. The tax base may be less in that area. So it creates some very serious problems in terms of national distribution of mental health resources, trained personnel.

Mr. MICHEL. Thank you.

Mr. CASEY. Thank you.

We will recess until 2.

[Recess.]

Mr. FLOOD. The committee will come to order.

Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

I don't have many questions because we went through so much of this last year.

MARIHUANA AND HEALTH

On marihuana just one question, Dr DuPont.

A number of weeks ago I noticed a study indicating that there might be some damage of white corpuscles caused by marihuana. I have since seen an article challenging that study. What is the situation?

Dr. DuPont. That was the study done by Professor Nahas at Columbia that I referred to earlier this morning. We are looking into that. This finding hasn't been reported by any other investigator. We want to get some clinical perspective on that finding.

PROGRAM INCREASES IN 1975 ADAMHA BUDGET

Mr. Obey. Dr. Egeberg, in looking for things that are not so gloomy in this budget, I do see on page 8 of your justifications that they did manage to include $200,000 for the construction of a perimeter fence around the animal center. I wanted to congratulate you on being able to get that.

On page 10 under drug abuse and then on page 11 under alcoholism, you show an increase of 71 positions for management and information, and 16 positions under alcoholism for management and information. That seems to be just about the only increase in that budget. Is that right?

Dr. Egeberg. Yes; that is true. The reason for it was a rather large increase in things to manage. Very little of this is information activities.

ADAMHA INFORMATION ACTIVITIES

Mr. Obey. That was my next question. How much of that is information and what kind of information are we talking about?

Dr. Egeberg. Allow me to speak a minute about information activities. In the Alcohol, Drug Abuse, and Mental Health Administration, when referring to information programs, usually we mean education programs. For example, we need to get scientific information to people who are dealing with patients who need treatment in alcohol, drug abuse, or mental health facilities. We gather information from our research projects, and we get it out to the people who need it to improve the delivery of services. There is very little self-aggrandizing information included in our activities. I would call most of it technical information.

But even at that, I doubt this represents more than 30 percent of the budget in this activity.

Mr. Obey. For the record would you include some examples of the kind of information you are talking about.

Dr. Egeberg. You would like that for the record?

Mr. Obey. Yes; because it is very essential when we go to the floor. There are two or three members I can think of who like to play with that kind of title.

[The information follows:]

Example of Information Programs Within the Alcohol, Drug Abuse, and Mental Health Administration

The information systems within the Alcohol, Drug Abuse, and Mental Health Administration have a basic purpose which is twofold: (A) To receive, analyze, interpret and evaluate current information and trends pertaining to the three general subject areas; and (B) To disseminate such information in a variety of ways and to audiences which include the scientific and academic communities, the clinical community, the professions which touch on mental health work in their normal activities, and the general public. Examples of information programs supported by the three institutes are provided below.

NATIONAL INSTITUTE OF MENTAL HEALTH

The mission of the National Clearinghouse for Mental Health Information is to provide for rapid and effective dissemination of information in order to shorten the gap between research findings and their practical application. To this end, emphasis has been placed on collecting comprehensive and specialized mental health information on an international basis. Since 1968, the Clearinghouse has pursued the policy of acquiring and processing mental health literature in all areas relevant to mental health. Today the NCMHI screens literature in more than 50 areas of interest to the mental health field.

The dissemination of information to mental health workers, professionals, and the concerned public remains the primary service function and responsibility of the Clearinghouse.

In addition to periodical and special publications, individual requests are answered through special searches of the computer files. These requests have grown from 1,735 in 1969 to over 6,300 for 1973. However, since each requester may ask for more than one topic, the number of single item searches has grown from 2,240 in 1969 to 10,754 in 1973.

A partial listing of periodical and one-time publications put out by the Clearinghouse is provided below. This listing, which comprises about 20 percent of the total publications list, includes source materials for the general public, library search materials, and substantive material suitable for various professional levels:

Abstracts of the Psychoanalytic Studies of the Child.
Aged Patients in Long-Term Care Facilities.
Cognitive and Mental Development in the First Five Years of Life.
Consultation in Mental Health and Related Fields.
Cost Finding and Rate Setting for Community Mental Health Centers.
Crime and Delinquency Topics.
Dealing with the Crisis of Suicide.
Directory of Halfway Houses.
Directory of Institutions for Mental Disordered Offenders.
Facts about Autism.
Facts About Adolescence.
Facts About College Mental Health.
Facts About the Mental Health of Children.
Functions of the Police in Modern Society.
Growing Up in America.
Handbook of Psychiatric Rating Scales.
Mental and Emotional Illnesses in the Yound Child.
Multi-Ethnic Literature in the High School: A Mental Health Tool.
NIMH Research on the Mental Health of the Aging.
NIMH Report to Physicians: Treatment of Insomnia.
Nursing Careers in Mental Health.
Promoting Mental Health in the Classroom.
Schizophrenia Bulletin.
Social Change and Human Behavior: Mental Health Challenges of the Seventies.
Suicide Prevention in the Seventies.
Teachers Talk About Their Feelings.
TV Media Content and Control.
TV and Social Learning.
Veterans with Mental Disorders 1968–1970.
Volunteers in Community Mental Health.
Youth in Turmoil.

NATIONAL INSTITUTE ON DRUG ABUSE

The Division of Scientific and Program Information within the National Institute on Drug Abuse collects, maintains, and disseminates a variety of program and management information. Systems supporting these objectives include:

The Integrated Drug Abuse Management Information System

The Integrated Drug Abuse Management Information System is a computerized management system designed to provide a two way flow of information between the National Institute on Drug Abuse, and other Federal agencies, and the States and localities across the country. Included in this network of communication is the Integrated Drug Abuse Reporting Process which consists of the actual reporting media established in each State Agency to send and receive client related data which are utilized by Federal agencies as well as States and localities in the development and operation of drug abuse treatment and rehabilitation programs. Also included is a centralized file which contains, for all major communities, data elements relating to their demographic and socioeconomic characteristics, their employment situation, their criminal justice system statistics and other factors describing them as geopolitical entities.

The Financial Management Information System

This system provides basic information tools to management at the Federal, State and local levels to ensure that resources are planned, allocated, and monitored in an efficient, legal, and accountable manner. It enables, for example, individual grantees who need management assistance to avail themselves of budgeting, accounting and administrative procedures from established management sources.

The National Clearinghouse for Drug Abuse Information

The National Clearinghouse for Drug Abuse Information collects and stores information from a wide variety of sources, and drawing upon this mass of data, produces numerous materials, including fact sheets, directories, bibliographies and other publications, which are distributed to the general and professional public as well as the Federal and non-federal government agencies.

Reference materials which consolidates the many record, posters, plays, and other materials available to schools and communities on the subject of drug abuse include "Selected Drug Abuse Education Films," which is a concise guide giving descriptive summaries as well as the method of obtaining many of these films.

The Clearinghouse has assembled volumes of its own information materials including pamphlets, flyers and reports. A few of the many reports dealing with the broad range of topics are "Methadone Maintenance Programs"; "Crisis Intervention: Current Developments"; "Community Action Programs: Voluntary Action and Drug Abuse: Some Current Highlights"; and "Drug Abuse Treatment and Prevention: Religious Activities and Programs." The most widely disseminated publication is "A Federal Source Book: Answers to the Most Frequently Asked Questions About Drug Abuse," produced jointly by the U.S. Departments of Justice; Health, Education, and Welfare; Defense; Labor; and the Office of Economic Opportunity.

The Clearinghouse has become a valuable reference source for researchers, clinicians, ~~and~~ others working in the field of drug abuse. Included in the wide range of reference materials are "The Annotated Bibliography on Drug Dependence and Abuse"; and "The Annotated Directory of Drug Abuse Programs" in the United States. These major directories are revised and reissued periodically to keep pace with current developments in the field.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Specific objectives of the NIAAA Public Information and Education Program include: (a) developing public recognition of alcoholism as an illness, and the alcoholic as an individual who needs help and can be helped, (b) encouraging the health system to accept alcoholism as a medical/social/behavioral problem and to treat the alcoholic with the same attention and consideration as any other patient, (c) developing public awareness on the effects of alcohol and the distinctions between responsible and irresponsible drinking, (d) producing a new national environment of frankness about the use and misuse of alcohol, and (e) achieving a concomitant reduction in the rate of drunkenness, problem drinking, and alcoholism by prevention through education. To achieve these objectives, the NIAAA established the National Clearinghouse for Alcohol Information to serve as a focal point for the collection and dissemination of world-wide information on alcohol abuse and alcoholism. The National Clearinghouse for Alcohol Information makes widely available the current knowledge on alcohol-related subjects. Alcohol and Alcoholism, a publication of the NIAAA presenting some highlights of modern research on drinking and alcoholism, has been provided on request to professionals in private medicine, public health, vocational rehabilitation, and the behavioral sciences. It has also been offered as a basic document on alcoholism to clergy, educators, military program personnel, labor and industry representatives and the interested public.

Some practical information on building a network of care for the alcoholic person and his family is available in "Developing Community Services for Alcoholics: Some Beginning Principles." This publication has been channeled to health and welfare specialists in emergency medical units, rehabilitation facilities, social services agencies, halfway houses and referral centers; it has been valuable for health planning council members and administrators as well. "Proceedings of the Joint Conference on Alcohol and Alcoholism" is of specific interest to and has been requested by numerous individuals involved in traffic safety, probation law enforcement, rehabilitation and the courts. The major conference objective was to assist in planning and programing at the regional, state and local levels in dealing with the alcoholic offenders, the drinking driver, and the public inebriate. The audience mentioned above has also received pamphlet material including: "The Drinking Driver and the Courts" and "The Drinking Driver and the Police." Items of general interest—"Alcohol: Some Questions and Answers," "Thinking About Drinking," and "Someone Close Drinks Too Much"—have been widely utilized by civic groups, libraries and information centers, educators, counseling and treatment agencies and the general public, to name only a few. Bibliographies with references to the scientific literature covering various aspects of alcoholism prevention, treatment, and research have been supplied on demand to alcoholism fieldworkers and individuals in related professions.

Dr. EGEBERG. Somebody asked this morning about the three agency clearinghouses. The one in mental health is one of the outstanding sources in the whole country for information dealing with modern knowledge in the field of mental health. We supply the knowledge to anybody in the field who asks for it.

CHILD MENTAL HEALTH STAFFING GRANTS

Mr. OBEY. Page 12 of your justifications it points out that in mental health "The increase of $7,844,000 will provide for funds for additional continuation costs. No new funds will be awarded."

I am especially interested in that area. I remember Dr. Brown mentioning in hearings last year that first admissions of kids under 15 to State mental hospitals had just about doubled since 1962. I am wondering how it is really possible to justify no new funds in a program area like that, given those statistics.

Dr. EGEBERG. It is like much of the other justification. We feel we have primed the pump and demonstrated with the States how much can be done. The feeling of the Administration is that this has been done well enough so that the States—and there are many indications that they will—are now going to take over more of this.

I don't know whether you were here this morning when I said that in community mental health centers, of which some of this is part, the Federal Government on the average pays for 30 percent of total operating costs and non-Federal sources including the States and counties pay the other 70 percent.

Mr. OBEY. I think you can argue that the opposite way. You can say they are spending 75 percent now and this is a pretty big share of the burden. Why increase it. We are talking about property taxes which hurt a lot more than income taxes do, at least in most cases.

The other point would simply be that State and local units of government may have been shown the way to a certain extent by the Federal Government, but the statistics seem to indicate you have more kids going into State hospitals than you had 10 years ago unless the figures have changed since last year

Dr. EGEBERG. I am afraid that is true.

EVALUATION STUDIES OF MENTAL HEALTH TRAINING PROGRAMS

Mr. OBEY. In response to the chairman's question earlier about your evaluation of your training program, you indicated that you would be happy to provide that for the record. But I note in hearings last year the chairman said to Dr. Brown "Last year you told us you were making an evaluation of your training program. Let us have a copy of that evaluation study. Also let us have a summary of the results of the evaluation for the record."

Mr. FLOOD. If the gentleman will yield, I am glad you asked that. I have before me last year's hearings. I had asked you earlier last year, we were told, that is what the gentleman refers to—an evaluation of the *NIMH training program is underway. I said to you.* "Has the evaluation been completed?"

"It hasn't been."

If the gentleman will refer to 158 at the end of the quotation you say "A preliminary report will be available in July 1973."

You told us that last year and that is why the gentleman is asking that question now. You told us last year it would be ready in July 1973. I meant to follow that up.

Dr. BROWN. We are completing our evaluation.

Mr. OBEY. What is slowing it down?

Dr. BROWN. Some administrative problems have slowed down the completion of this report.

As we noted this morning, a preliminary draft has been completed. However, the general policy decision to have the Federal Government phaseout support for health manpower training is so clear that the evaluation might not have an impact.

Mr. FLOOD. I knock on the door and now I come in. What did you say?

Dr. BROWN. I am trying to put this as cogently and diplomatically as possible. But the command decision was so clear that the evaluation study might not have changed that command decision no matter what it said.

Mr. OBEY. In other words don't confuse us with the facts.

INDIAN ALCOHOLISM PROGRAMS

Someone mentioned the Indian alcoholism program. What percentage of Indians have been reached by that program over the last 2 years?

Dr. CHAFETZ. Our best estimate is that the Indian alcoholism programs which have been developed by the Indian people in concert with the Alcohol, Drug Abuse, and Mental Health Administration have reached no more than 20 percent of the real need.

Mr. OBEY. You don't really think if you have to rely on community support you are going to be able to reach many more Indians in the next year or two do you?

Dr. CHAFETZ. On the basis of evidence that we have, I don't think we could make a definitive statement that is possible. I think it is a fact we all know that in the sharing of resources historically the Indian people have gotten short shrift.

It is our hope with the formula grant programs that have been made available to the States and the success of the self-determination program on alcoholism that the Indian people have effected that they will do better. But I have no way of knowing whether that will be an historical reversal.

Mr. OBEY. It is my hope, too, but my knowledge of seven or eight Indian tribes in my State leads me to conclude that hope is in no way related to reality. That just isn't going to happen.

Indians have been treated badly enough by the Federal Government but you get down to the local level and it can be even worse. I think it is completely unrealistic and primitive to assume the needs of the American Indians, as far as alcoholism or any other program is concerned, will be met at the State and local level without considerable Federal prodding. It isn't going to be done and I think the record in every program area I can think of would bear that out.

Mr. FLOOD. I would like to say, Doctor, I don't have any Indians in my hard coal district.

With reference to the Federal part of it, certainly a blot on the face of America's escutcheon is the treatment of the American Indian, and now most unfortunately in the area with which you are concerned. I wish and I am sure my friend and all of the subcommittee will join me, when you get the record will you devote something to a case history of this program with the American Indian at as much length as you think it reasonable under the circumstances?

Dr. CHAFETZ. I not only welcome that opportunity, Mr. Chairman, I deem it essential.

[The information follows:]

CASE HISTORY ON THE PROGRESS OF INDIAN ALCOHOLISM PREVENTION AND TREATMENT

Since its establishment in 1971, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has recognized the special severity of alcoholism problems among American Indians and has made support of alcoholism programs for them one of its top priorities. In 1971, the NIAAA funded 12 projects in the amount of $750,000 to combat alcoholism among the American Indians and Alaskan Natives. During fiscal year 1972, 45 new Indian projects were funded for a total cost of $3,341,726. In fiscal year 1973, the NIAAA supported 97 Indian alcoholism projects totaling $6,498,518 in both urban and reservation areas and is continuing these programs in fiscal year 1974. We have taken precautions to insure that they are, in fact, intrinsically Indian. The program guidelines stipulate that each project demonstrate Indian community initiative and self-determination, as manifested by Indian control over the administration, operation, and staffing of the programs.

The primary objective of the NIAAA and the Indian alcoholism program is to assist in making the best alcoholism treatment and rehabilitation services available at the community level. To accomplish this objective each program is designed to provide a variety of services which may include residential care, including room and board, for problem drinkers who seek help—individual counseling, job placement, referral service, group therapy, Indian AA groups, didactic lectures, work therapy, recreation and self-government. Other methods which are being utilized to help Indian communities solve their alcohol abuse problems include broad programs of public education, training of Indian people, and development of community services.

Since their inception, the Indian alcoholism programs have had a significant impact upon the Indians' attitude toward drinking—the first vital step in recovery. The communities and Indian tribes living on reservations have gained valuable knowledge about alcohol abuse and are now viewing alcoholism as a major social, cultural, and economic problem. Other alcoholism programs without Federal funds are being developed, and community resources are being organized in a concerted effort to meet the needs of Indian people afflicted by alcohol. The following are examples of the results achieved by our alcoholism programs:

Fifty percent of our Indian alcoholism program clients recover and become productive citizens—10 percent of these become sober—40 percent change drinking patterns for the better (family relationships are improved).

Fifteen to twenty percent get jobs through the programs—this is especially important with exceedingly high rates of Indian unemployment.

Our programs are encouraging Indians in Federal, State, and local jails with alcohol problems to enter into treatment programs after release.

Approximately 100 Indian Alcoholics Anonymous groups have been established—a remarkable achievement, since prior to our programs Indian people traditionally shunned AA groups.

To further carry out it's objectives an Indian Desk is maintained within NIAAA. It is staffed by experienced Indian people to monitor, assist, and advise these programs. In addition, it is charged with the responsibility of maintaining close liaison with concerned Federal agencies involved in health care and social service delivery to Indian people, as well as with national Indian advocate organizations. The NIAAA also employs the American Indian Commission on Alcohol and Drug Abuse (AICADA) to provide technical assistance to isolated American Indian communities on and off the reservation. AICADA, located in Arvada, Colo., has earned an enviable reputation as an organization representative of Indian interests with experienced in combating the unique problems associated with alcohol abuse among the American Indians.

In the area of prevention, the NIAAA has explored with chiefs and medicine men aspects of the Indian culture which may be useful in providing alternatives to excessive drinking. In Oregon, the NIAAA sponsors an alcohol education program run by Indian students in a residential school. In addition, we have launched a national education campaign to inform the American people that alcoholism is an acceptable, treatable illness. This effort has had an impact on the Indian people.

To parallel the above efforts of NIAAA, a special "minigrant" program was launched in fiscal year 1973 to provide $5,000 to $10,000, 1-year project grants to Alaskan Native communities to assist their people in developing their own alternatives to combat alcoholism among the Alaskan Native people. During fiscal year 1973, the NIAAA funded 44 Alaskan Native minigrants in the amount of $472,826. Since 1973, 122 additional new minigrant applications have been received and recommended for approval. During fiscal year 1974, the NIAAA will support approximately 160 Alaskan Native minigrants totalling $1,600,000, and approximately $900,000 will be utilized for other activities focusing on the Alaskan Native.

The overwhelming response of the Alaskan Native people has been to construct, remodel, or rent village centers to serve as focal points for Alaskan Native people in which to engage in a variety of constructive activities such as arts and crafts, youth and adult recreation, repair and sale of small machinery such as snow equipment, employment training, village meetings and AA meetings. The variety of planned activities and equipment are regarded by the Alaskan Native communities as their most urgent need and most effective way to begin helping their people face and overcome their drinking problems.

Another collaborative effort which will soon be underway on behalf of the Alaskan Natives is a public information campaign. As a result of a special appropriation, NIAAA has allocated funds for the specific purpose of developing a massive statewide public information media campaign which will stress prevention of alcohol abuse and alcoholism. This activity is beng carried out with key people in the State of Alaska who are currently involved with the various alcohol programs. It is anticipated that the organizational work will commence at the beginning of fiscal year 1975.

In addition, the construction of the Alaska pipeline will have a tremendous impact upon the Alaskan Natives. We anticipate that the pressures and problems associated with this project will cause immediate changes in the incidence of alcohol problems and alcoholism in Alaska. To counteract this problem, the NIAAA is currently exploring the possibilities of implementing additional prevention activities prior to the advent of the pipeline construction. Studies are underway to develop programs to provide information and education to the villages, training programs in conjunction with the University of Alaska and counseling programs.

INDIAN HEALTH SERVICE—ALCOHOLISM PROJECTS

	Fiscal year 1973	Fiscal year 1974	Fiscal year 1975
Congressional request	$266,000	$266,000	$266,000
Appropriation	266,000	266,000	
Operating level	266,000	266,000	

Beginning in fiscal year 1972, an additional $266,000 has been available annually to initiate and expand tribal programs in alcoholism prevention and control in those Indian communities that had no existing resources. A total of 18 small community alcoholism programs, Indian conceived and managed were able to be initiated in fiscal year 1972.

In fiscal years 1973 and 1974 some of the previously funded projects were continued, a few were funded in full amount by the National Institute on Alcoholism Abuse and Alcoholism, and several of the projects that were previously unfunded were initiated.

These projects have served a definite need that could not otherwise be met. Present use of these monies continues to meet needs for the small community project, which proves to have merit for that community.

Indian alcohol programs are funded primarily from the NIAAA Special Projects division which has been designated as the funding source for Indian Alcoholism projects.

The problem of alcohol abuse and alcoholism among Indian people requires excellent technical assistance in developing Indian alcoholism programs, training for Indian people, research into psychosocial variables of alcohol abuse and alcoholism among Indian people and sufficient funding is a continued basis into the future if this serious health problem is to be effectively met.

INDIAN HEALTH SERVICE

[Dollars in thousands]

	1973	1974	1975
Budget request	$213,022	[1] $236,686	$280,999
Appropriation	220,090	234,210	
Operating level	219,958	[1] 250,264	

[1] Includes $16,001 in supplemental requests.

All of the congressional increases to the fiscal years 1973 and 1974 budget requests for Indian Health have been obligated at this time. Further, the ongoing annualized costs of these increases and the fiscal year 1974 supplemental are reflected in the 1975 budget request. The fiscal year 1975 budget request also provides for nonpolicy mandatory cost increases and a program increase for ambulatory care. These increases will reduce the backlog of unmet Indian health needs.

Mr. FLOOD. I have a visceral sensation very recently, a matter of a couple of years, even this year I know on the floor of the House and in committees there is an increasing awarness that there are American Indians.

INDIAN HEALTH SERVICE PROGRAMS

Mr. MILLER. When we provide that additional information you just requested, Mr. Chairman, I would like to add to it the effort we are undertaking in the Indian Health Service which comes before another subcommittee, which I think Mr. Obey was once a member of.

Mr. FLOOD. I have that in mind.

Mr. MILLER. We have a significant initiative there. We have a $30 million increase in that budget, and I know some of it is going toward alcohol projects.

Mr. OBEY. If there is an increase in the Indian health budget a good portion of it is restoration of the cut accomplished last year.

Mr. MILLER. I don't believe so. Our own budget covered the mandatory costs last year and Congress increased it. We spent that money. There hasn't been a decrease in the Indian Health.

Mr. OBEY. I will go back and check it again but my recollection is that the money which we included in the supplemental 2 years ago hadn't been spent last year.

Mr. **Miller**. I am reasonably certain that the supplemental in 1973 and the congressional increase in 1974 were ultimately spent. I agree it took a long time but it was done.

REDUCED BUDGET REQUEST FOR ALCOHOL PROGRAM

Mr. **Obey**. Let me ask Dr. Egeberg one more question. I think I recall the President's message on drug abuse—I may have the wrong speech—made the assertion last year that alcoholism was the worst drug problem we had in this country. In light of this budget I wonder if there is anybody in this room who can tell me what has happened to change that?

Dr. **Egeberg**. I would rather Dr. Chafetz did, but I am aware of the fact that a number of the projects supported in alcoholism, began about 3 years ago and receive their final year of support this year. That is one reason for the reduction in the fiscal year 1975 budget.

I think Dr. Chafetz would be more approximately prepared to go into further detail on this.

Dr. **Chafetz**. Mr. Obey, I think the situation vis-a-vis alcoholism and the request for fiscal year 1975 funds is such that many of these programs that we will be supporting both with the fiscal year 1974 funds and the released fiscal year 1973 funds will get started so late that they don't really impact on the budget you have before you. So I think that is why we will not be cutting down.

At the same time, as Dr. Egeberg correctly points out, many of these projects are ending their period of demonstration and our commitment to them is at an end.

Mr. **Obey**. I am somewhat concerned because you yourself indicated this morning that you have a large switch from other drug use to alcohol, and I just don't think this budget sufficiently reflects that increased problem.

Dr. **Chafetz**. Mr. Obey, I think that having been in Washington now for about 3½ years I recognize that the appropriations process has the Executive preparing the budgets and then Congress lends its wisdom, and I promise you the Alcoholism Institute will spend whatever moneys are appropriated to it wisely and well.

Mr. **Obey**. I have never heard that said before.

Mr. **Flood**. Let me say it this way—I couldn't have said that better myself. That is praise from Caesar.

Dr. **Chafetz**. Mr. Chairman, you know what happened to Caesar?

Mr. **Flood**. He was good too.

TERMINATION OF FEDERAL SUPPORT FOR CMHC'S

Mr. **Obey**. One other question on the community mental health centers, and I asked about the same thing last year of Dr. Brown.

Let me give you an example in my own district to spell out what I think happens when you terminate those programs. Then I would like to have your response as to whether or not I am wrong in my conclusion.

Last year I had two communities in my district, my own hometown city, Wausau, which had built and staffed a community mental health center in the past 2 years. That is a fairly wealthy town as towns go in my district. The other town which was slated to get assistance to construct and staff one of those centers was a town further north by the name of Ashland. That was a much poorer town. The unemployment at that time was around 10 to 12 percent I believe. The unemployment in the northern half of my area around the city of Ashland is about double what it is in much of the southern part.

It is my observation that what you do when you cut off these projects from funding is that you really penalize the community which perhaps needs the assistance the most. I know there has been a higher level of funding for your poverty areas, but despite that, just because of the nature of community leadership which you have in a town which is better off as opposed to the town which is hurting economically, you have the town that have been well off apply for these funds, recognize their needs, build what they have to build and the other towns that are a little slower to catch on about Federal grantsmanship a little more reluctant to ask for outside help, are the ones who have less services of these kinds. Yet that community probably needs that kind of service more than my own hometown.

Would I be wrong to conclude that is likely to be the pattern generally across the Nation?

Dr. **Egeberg.** I can assure you Dr. Brown has tried very hard, as you referred to in part of what you said, to see that poverty areas received more rather than less support than the average community.

On the other hand I can well imagine a place that does not have adequate local funds might have difficulty receiving support.

I wish Dr. Brown would enlarge on that.

Dr. **Brown.** Mr. Obey, it is hard to take a piece of it. Let me respond to it in a bigger context.

We will at the end of this coming year have 626 centers which are funded and 536 that are operational.

We estimate there are another 75 centers that have gotten underway by State and local efforts without the Federal construction or staffing help.

I am fond of saying we are halfway home, have covered half the Nation. The issue before us is what we do about the uncovered half of the Nation.

There are three tools available—love, technical assistance, and money. We will use any one or all of those three. If we have within our grasp love and technical assistance that is what we will use. If money is made available, I think that will move the situation obviously that much faster.

ECONOMIC STATUS OF COMMUNITIES SERVED BY CMHC'S

Mr. **Obey.** Is there any way for you to provide this committee with a measure of the economic well-being of the communities which have had centers established under this program versus the communities which would have been scheduled to get them 2, 3, and 4 years down the line?

Dr. **Brown.** We have excellent data on that because of the nature of poverty grants which have the 90-percent matching. Across the country areas are divided into poverty and nonpoverty areas. Nearly 60 percent of the Federal money goes into poverty areas, 40 percent in nonpoverty areas.

Mr. OBEY. That is an entirely different question because you have a different matching arrangement; do you not?

Dr. BROWN. That is correct.

Mr. OBEY. What I am asking, do you have a list of communities right now and could you tell which were the next 200 areas which would receive those centers?

Dr. BROWN. We can provide that.

Mr. OBEY. My question is could you take those next 200 and is there any way you can measure what the average per capita income is in those communities and compare it to the average per capita income of the communities who have constructed centers up to now?

Dr. BROWN. Yes. It is a bit of work but it can be done. I will be glad to work that out and provide it.

Mr. OBEY. I would be interested.

Dr. BROWN. It is an interesting kind of question, to see whether or not the next 200 would be lower per capita or higher per capita and how they would compare with those that have been funded to date. We will be glad to do that.

[The information follows:]

PER CAPITA INCOME OF AREAS SERVED, BY EXISTING COMMUNITY MENTAL HEALTH CENTERS COMPARED WITH THAT OF NEXT 200 CENTERS

At the present time, there are 58 community mental health centers applications approved by the National Advisory Mental Health Council but unfunded. In addition, the 10 regional offices are in the process of receiving many new applications. These will be reviewed by the Council at the June 1974 meeting. Until this process has been completed, it will be impossible to determine specifically the next 200 community mental health centers to be funded. We have, therefore, provided a listing of the 58 approved but unfunded projects and the median income of their catchment areas. We cannot guarantee that these would be "the next 58," or even 58 of the next 200 to be funded since the responsibility for deciding which particular project is funded rests with the Regional Health Administration in the DHEW regional offices. These decisions are made, however, within national priorities and objectives established by the headquarters office.

We have computed the average median income of these approved but unfunded applications to be $6,925 as compared to $6,883 for centers already funded. The slight variance upward is attributable to the fact that a large number of severe poverty areas have already received centers support. Approximately 59 percent of all funded centers serve poverty catchment areas. In addition, the centers listed represent those not selected for funding in prior years, in many cases because poverty grants were given priority over nonpoverty or less indigent poverty grants. The 58 unfunded centers follow.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

APPROVED/UNFUNDED APPLICATIONS FOR COMMUNITY MENTAL HEALTH CENTERS

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
04-D-000005-01 Mobile MHC Mobile, Alabama	Baldwin County (Catchment Area M-16C), and census tracts 1-5 and part of 12 in the Mobile Standard Metro Stat. Area	82,249	$5,257
06-H-000320-01 Human Services Center of West Central Arkansas Russellville, Arkansas	Six counties: Conway, Faulkner, Johnson, Perry, Pope, Yell	118,731	$[illegible],409
09-D-000330-01 Santa Cruz Family Guidance Center Nogales, Arizona	All of Santa Cruz County in Arizona and south into Sonora, Mexico to include the community of Magdalena.	75,000	$6,747
09-D-0000001-01 East Los Angeles Health Task Force Los Angeles, California	Catchment area #100 in East Los Angeles	156,260	$7,420
09-H-000315-01 East Sacramento County Mental Health Services Sacramento, California	Major Eastern and Southeastern portions of Sacramento County Includes Census Tracts: 52, 54, 80, 82-94	112,983	$9,562
09-H-000320-01 District V CMHC San Francisco, California	District V encompasses the western third of the city. Three geographical sub-districts constitute the catchment area: Richmond, Sunset and OMI.	182,263	$9,466

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
08-H-000084-01 Pikes Peak Family Counseling & MHC Colorado Springs, Colorado	Catchment area consists of two counties: El Paso, and Teller	239,238	$6,058 (est.)
08-H-000130-01 Malcolm X Center for Mental Health Denver, Colorado	Northeast quadrant of Denver - Census tracts: 33, 35, 36, 02-03, 38, 41.01-05, 42.01-02, 43.01-05, 44.01-02, 83.01.	114,843	$7,264
08-H-000083-01 Southwest Denver Mental Health Services Denver, Colorado	Barnum and Valverde District: Census tracts: 9.02, 9.03, 10. Westwood Area-Census tracts: 45.01, 45.02. Athmar Park - Census tracts: 13.01, 13.02. Marlee District - Census tracts: 46.01, 46.02. Harvey Park District - Census tracts: 46.03, 47, 48.01. Bowmar Heights, Pine - Census tracts: 48.02, 119.01. Bowmar Heights, Pinehurst, Bear Valley Districts - Census tracts: 119.02, 119.03, part 120.01, part 55.01, part 55.03. Ruby Hill, College View - Census tracts: 14.01, 14.02, 54.01, 54.02. Centennial Acres - Census tracts: 55.03.	89,760	$9,728
04-D-000003-01 Pinellas County MH Board & Adult MH Clinic St. Petersburg, Florida	The south seven miles of the Pinellas Peninsula, including over half of the City of St. Petersburg and St. Petersburg Beach.	169,332	$5,489

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
04-D-000009-01 Tampa Area Mental Health Board Tampa, Florida	The Northeast portion of Hillsborough County and all of Hernando and Pasco Counties, which includes the Northeast portion of the City of Tampa, and the towns of Brooksville, Dade City, Zephyrhills, and New Port Richey.	191,046	$5,700
04-D-000006-01 District II Mental Health Board Valparaiso, Florida	District II: The counties of Walton, Santa Rosa and Okaloosa.	142,000	$6,295
10-H-000049-01 South Central Idaho Mental Health Center Twin Falls, Idaho	Eight Counties: Blaine, Camas. Cassia, Gooding, Jerome, Lincoln, Minidoka, Twin Falls.	102,987	$6,474
05-D-000002-01 Mental Health Foundation of Monroe County Bloomington, Indiana	The counties of Lawrence, Monroe, Morgan, and Owen.	179,226	$5,777
05-H-000-[illegible]57-01 Tri-City Comprehensive CMHC E. Chicago, Indiana	Catchment area is in North Lake County in Northwest Indiana --concentrated in cities of Hammond, East Chicago and Whiting. Census tracts: 201-218, 301-310, 401-402.	162,019	$9,155
05-D-000003-01 Community Mental Health Center Lawrenceburg, Indiana	The counties of Dearborn, Franklin, Ohio, Ripley, and Switzerland in Southeastern Indiana.	78,106	$7,346

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
06-H-000317-01 Margaret Dumas Memorial Mental Health Center Baton Rouge, Louisiana	East and West Feliciana Parishes and a contiguous, urban portion of East Baton Rouge, including census tracts: 30, 30.99, 31, 32.01, 33, 41, 42.01, 42.02, 42.03, 46.	81,217	$5,638
03-001702-01 Northern Baltimore County CMHC Towson, Maryland	Northern Baltimore County Catchment Area, in Area I of the State, Election Districts 5-10, census tracts, per claritas: 4050, 4060, 4071, 4072, 4081-4089, 4101-4102, 4901-4917, 4919, 4920.01-02, 4921.01-.02, 4922.	161,220	$12,000
01-D-000002-01 Haverhill/Newburyport Human Services, Inc. Bradford, Massachusetts	The municipalities of Haverhill, Newburyport, Amesbury, Groveland, Georgetown, Merrimac, Salisbury, Boxford, Newbury, Rowley, West Newbury (The Haverhill-Newburyport Area of Northeastern Massachusetts.	105,541	$8,632
01-D-000001-01 Mental Health Association of North Central Massachusetts Fitchburg, Massachusetts	The Fitchbutg Area, which includes the cities of Fitchburg and Leominster, and the towns of Ashby, Ayer, Berlin, Bolton, Clinton, Groton, Lancaster, Lunenburg, Pepperell, Shirley, Sterling and Townsend.	141,283	$8,520
01-D-000003-01 Cape Ann Children & Family Center Gloucester, Massachusetts	The communities of Beverly, Essex, Gloucester, Hamilton, Ipswich, Manchester Topsfield, Rockport, and Wenham (The Greater Cape Ann Mental Health and Retardation Area).	106,000	$9,181
01-D-000006-01 Greater Lawrence Mental Health and Mental Retardation Area Board Lawrence, Massachusetts	The City of Lawrence and the surrounding towns of Methuen, Andover, North Andover, (the Northeast portion of Massachusetts).	142,350	$8,906

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
01-D-000008-1 New Rootes Program North Adams, Massachusetts	Northern Berkshire County	45,941	$8,550
05-H-000367-01 Southwest Detroit Community Mental Health Center Detroit, Michigan	Catchment Area #12: Census Tracts: 2-13, 15, 20, 35-36, 38-39, 41, 51-56 58-64, 66-73, 101, 103-119, 121-123,	160,607	$7,077
05-D-000009-01 Detroit-Wayne County CMHC Service Board Detroit, Michigan	East Side Detroit and Central Detroit (two catchment areas).	294,202	$6,312
04-D-00010-01 Yellow Creek-Tom Bigbee MH/MR Commission Corinth, Mississippi	The counties of Alcorn, Prentiss, Tippah, and Tishomingo.	78,104	$4,979
04-D-000007-01 Region VI MH-MR Commission Greenwood, Mississippi	The counties of Carroll, Grenada, Humphreys, Leflore, Montgomery, and Sunflower in the Mississippi Delta.	178,618	$3,463
04-D-000011-01 Southwest Mississippi MH-MR Commission Magnolia, Mississippi	The counties of Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall and Wilkinson (Southwest Mississippi Development District).	171,138	$4,020
04-D-000002-01 Region XII Mississippi MH-MR Commission Sumrall, Mississippi	The counties of Covington, Forrest, Greene, Jones, Lamar, Perry and Wayne in South-central Mississippi.	213,484	$4,520

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
07-000139-01 Northeastern Jackson County CMHC Independence, Missouri	Catchment Area V- in Northeast quadrant of Jackson County - 36 Census tracts: 5-8, 19-23, 106-, 107.01, 107.02, 109.01-.02, 110-124, 140, 145-151.	176,928	$9,102
08-H-000058-01 West Central Montana Regional CMHC Anaconda, Montana	Region III - Counties: Lewis & Clark, Powell, Granite, Dear Lodge, Boadwater, Meagher, Silver Bow, Beaverhead, Madison, Gallatin, Jefferson.	155,903	$6,542
02-D-000004-01 Atlantic Area Guidance Center Atlantic City, New Jersey	All of Atlantic County	175,043	$6,819
02-H-000325-01 St. Mary's Hospital CMHC Hoboken, New Jersey	Catchment Area #40: Hudson County Three Cities: Hoboken, Union City, Weehawken.	117,300	$7,010
02-H-000093-01 Christ Hospital CMHC Jersey City, New Jersey	Catchment Area 42 of Hudson County is that is that part of Jersey city which includes the following: Census tracts 1-16; 18-21; and 28-32.	99,991	$7,652
02-H-000324-01 Jersey City Medical Center CMHC Jersey City, New Jersey	Catchment Area 43 in Hudson County, census tracts: 17, 22-27, 31, 33-40, 41.01, 41.02, 42-43.	111,887	$7,288

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
02-H-000239-01 Monmouth Medical CMHC Long Branch, New Jersey	Catchment Area 28 - "a pie-shaped wedge" running through the center of the county from the Atlantic (Monmouth County) Ocean to the Manalapan Township. Townships: Colts Neck, Freehold Township, Shrewsbury Boro, Sea Bright, Deal, Eatontown, Little Silver, Ocean Township, Shrewsbury Boro, Fair Haven, Long Branch, Oceanport, New Shrewsbury Boro, Shrewsbury Township, Freehold Boro, Monmouth Beach, Rumson, West Long Branch.	131,507	$8,983
02-H-000295-01 Riverview CMHC Red Bank, New Jersey	Area 26 - a part of Monmouth County - approximately the Northern third - broken into several geographical regions: Bayshore, Highlands, Matawan, Union Beach, Keyport, Keansburg, Middletown, Atlantic Highlands.	182,427	11,064
06-D-000008-01 Rio Del Norte Planning Committee Espanola, New Mexico	Taos, Rio Arriba, Los Alamos and Santa Fe in Northern New Mexico.	116,930	$6,537
02-H-000019-01 Queens Hospital CMHC Jamaica, Queens, New York	Eight Health Areas of Central Queens: 20, 21, 20.22, 21.30, 27.20, 28.10, 33.34, 35.10.	205,000	$7,160
02-D-000012-01 Clinton County Mental Health Service Plattsburg, New York	The counties of Clinton and Essex	107,565	$6,311

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
04-D-000008-01 New Hanover County Wilmington, North Carolina	The counties of New Hanover, Pender, and Brunswick	125,368	$6,164
05-H-000360-01 Westside Community Help Center Cleveland, Ohio	West and near West side, City of Cleveland.	132,850	$7,300
05-D-000004-01 Community Guidance & Human Services Planning Committee Cleveland, Ohio	Catchment Area #6. Neighborhoods of Hough, Norwood, Central-East, Near Town, and Central West.	129,335	$4,070
05-D-000006-01 Franklin County MH & MR Board Columbus, Ohio	North Central Catchment Area (from Broad Street on the South, Olentangy River Road on the West, Oakland Park on the North and Alum Creek on the East.)	149,772	$3,542
05-D-000007-01 Day-Mont-West Mental Health Corp. Dayton, Ohio	Dayton Central (Catchment area #63) and West Montgomery County (Catchment area #66); Area #66 includes Preble.	65,479 (#63) 88,680 (#66)	$6,146 (#63) $9,582 (#66)
06-H-000336-01 Jim Taliaferro CMHC Lawton, Oklahoma	Eight counties in Southwestern Oklahoma: Caddo, Comanche, Cotton, Harmon, Jackson, Jefferson, Stephens, and Tillman.	243,346	$4,902
03-H-001728-01 Intercommunity Action Inc. Philadelphia, Pennsylvania	Northwestern part of Philadelphia - Area 6A includes the communities of Andorra, Shawmont, Roxborough, Manayunk, Wissahickon, East Falls and a small section of lower Germantown, bounded on west by Schuylkill River, on North by Northwestern Avenue, on East by Wissahickon Avenue, on South by Hunting Park Avenue.	73,420	$10,800

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
03-H-001722-01 Southwest Pittsburgh CMHC Pittsburgh, Pennsylvania	Area 9E-1, southwest of Pitsburgh proper. Census tracts: 1601-1605, 1701-1703, 1801-1806, 1901-1910, 2001-2012, 2801-2806 2901-2903, 3001, 3201-3204, 4811-4813.	169,297	$7,868
04-H-000812-01 York-Chester-Lancaster MHC Rock Hill, South Carolina	Catchment Area is composed of three rural counties located in North Central part of South Carolina: York, Chester and Lancaster.	158,355	$8,500
06-D-000007-01 City Health Department Crystal City, Texas	Catchment Area MH 9-1, Alamo Planning Area in Southwest Texas on the Mexican border.	94,961	$4,411
08-H-000133-01 Bear River MHC Brigham City, Utah	District I catchment area consists of the three northernmost counties in Utah: Box Elder, Cache and Rich.	72,075	$6,162
01-H-000236-01 Comprehensive Mental Health System Southeastern Vermont Bellows Falls, Vermont	Windsor and Windham Counties of Region IV, in Southeastern corner of Vermont.	77,156	$7,503
01-H-000136-01 Champlain Valley MHC Burlington, Vermont	Four counties in Region I: Addison, Chittendon, Franklin and Grand Isle.	158,253	$6,939
03-D-000788-01 Richmond Subarea A-1 CMHC Richmond, Virginia	Catchment Sub-Area A-1 in City of Richmond including Church Hill and Fulton Areas.	·125,000	5,858

NAME AND ADDRESS	AREA TO BE SERVED	POPULATION	MEDIAN INCOME
03-D-001-701-01 Department of Mental Health & Hospitals Saluda, Virginia	The counties of Essex, Gloucester, King and Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond and Westmoreland (Mental Health Planning Regions 17 and 18).	36,348 (#17, 47,609 (#18)	$4,908 (#17) $6,096 (#18)
10-H-000047-01 Highline-West Seattle MHC Seattle, Washington	Catchment area covers a portion of Southwest Seattle, Southwest King County and Vashon Island.	203,029	NA
03-H-000760-01 Valley Comprehensive CMHC Morgantown, West Virginia	Region V, Catchment Area I Four counties: Marion, Monongalia, Preston and Taylor.	282,258	$7,238
02-H-000321-01 Cayey CMHC Cayey, Puerto Rico	Three municipalities: Cayey, Cidra, and Aibonito.	82,368	$337.00 - Cidra $615.00 - Aibonito $764.00 - Cayey

Mr. **Obey**. That is all, Mr. Chairman.
Mr. **Flood**. Mr. Robinson.

FUNDS RELEASED FROM THE FISCAL YEAR 1973 APPROPRIATION

Mr. **Robinson**. Doctor, at the bottom of a good many pages in your justification there are several statements, indicated by asterisks, excluded such and such amount of funds of appropriations restored. But I don't see any place in the justification where we have the total amount of such funds that have been restored with regard to the institutes we are discussing this afternoon. What is the total amount that is involved that is still available of these restored funds?

Dr. **Egeberg**. I think the total amount is within the parentheses at the bottom of the pages.

Mr. **Robinson**. I wanted to add it up.

Dr. **Egeberg**. $139,882,000 for the Alcohol, Drug Abuse, and Mental Health Administration.

Mr. **Robinson**. These are funds that are still available?

Dr. **Egeberg**. That we have available to obligate.

Mr. **Robinson**. And have to be obligated by the end of this fiscal year?

Dr. **Egeberg**. The fiscal year 1973 funds, by February 7, 1975.

RURAL MENTAL HEALTH ACTIVITIES

Mr. **Robinson**. I represent a large rural area, and as a Member of Congress representing such areas that are becoming increasingly fewer as time goes on, I have some concern about the equitable availability of, not just these programs, but all federally funded programs to all of my constituents. I wonder in this connection if you would comment on what you consider to be the current availability and equitability of mental health services and the other related services we are discussing today with respect to small communities in rural areas. This is an extension of what Mr. Obey was asking about.

Dr. **Egeberg**. I would like to impose on Dr. Brown again to tell you about that.

Dr. **Brown**. We had some pretty interesting figures on how at least in the rural county mental health, rural and very rural, have fared. Quite well. Partly because of the poverty funding initiative.

Two hundred and thirty of the community mental health centers, that is, 42 percent of all of the centers funded, were in 784 predominantly rural counties outside the standard metropolitan district. Somewhat more than you would have awarded with just population equation.

So we even have broken it down to how well the 500 poorest rural counties, which are called very, very rural, I think 11 persons per square mile, have fared, and there too we have managed to cover about a third of those counties. Again a little touch more than if they had just gotten their fair shake so to speak in terms of urban, suburban, and rural populations. In that sense we paid special emphasis to the rural. It leaves again before us the fact that somewhere between one-half and two-thirds do not yet have Federal coverage.

EQUITABILITY OF DISTRIBUTION FORMULA

Mr. ROBINSON. My question goes a little deeper than that. I am wondering whether or not you think that the formula that you are using is the proper formula, the best formula, under the circumstances, or whether in order to be more equitable it should be changed.

Dr. BROWN. It is not the best because there is definitely a higher cost that just has to do with distance and transportation one has in addition to per capita income. You can have a tight eight block area that has $3,000 or less, and you can have literally 18,000 square miles with the same number of people. It just costs more to take into account the geographical dispersal, the transportation to satellite clinics.

We have never figured out a way of getting that into the distribution to give the extra inch of weight to that particular dimension.

Mr. ROBINSON. Do you continue to give thought to it, however, in terms of the possibility of doing so?

Dr. BROWN. If there is a new law that permits the program to be continued, I can assure you this will be taken into full account. But there is no need for it as things presently stand.

ALCOHOLISM POVERTY TREATMENT PROGRAM

Mr. ROBINSON. On page 46 of your justifications, you talk about the poverty program and you go back to fiscal year 1973 and say that 160 grants were funded under the community alcoholism services, poverty program. And from then on you talk about other programs but you do not again mention this particular area.

What is the status of that program and why don't we find further mention of it as we go down the explanation?

Dr. CHAFETZ. Mr. Robinson, as you probably remember, the NIAAA at the end of fiscal year 1972 took over about $14.4 million worth of Office of Economic Opportunity projects, allowing us to target in on the poverty areas. We are not only pleased but gratified by the response.

However, at the time the commitments for the transfer was made we had guaranteed that the Institute would be responsible for just 2 years of continuation funding which terminates, as the President's budget reads, with fiscal year 1974 funds. Certain high priority innovative programs, however, will be continued in fiscal year 1975 for approximately $6 million, including some poverty programs, if the budget is approved as it is.

ALCOHOL RESEARCH AND TREATMENT PROGRAM

Mr. ROBINSON. Continuing our discussion and recalling that certainly based on the discussions so far alcoholism seems to be becoming a more significant rather than less significant problem, on page 3 of your statement you mention in support of the National Institute of Alcohol Abuse and Alcoholism: "More than 100 research investigations ranging from studies of the etiology of liver cirrhosis and other alcohol-related disease, to careful examination of the withdrawal syndrome and its treatment."

I wonder to what extent your budget is allocated to the treatment of alcoholism medically speaking vis-a-vis the cirrhosis of the liver and to what extent it is concerned with the rehabilitation as the withdrawal syndrome would indicate?

Dr. CHAFETZ. Mr. Robinson, that is a very important question.

As a physician, as a health professional, I would say one of the problems of the condition had been that we just dealt with certain segmented aspects of it and have forgotten about the whole individual and his family and his society.

Our approach is for community-based total resources in order to respond to the needs of the individual, so that we have never broken down our programmatic support where somebody is going to take care of his liver and that is all we care about. We are interested in the total picture and building it into the whole health delivery system.

Mr. ROBINSON. Then of these 100 research investigations there is no breakdown as to which of those are medically oriented and which are not?

Dr. CHAFETZ. I am sorry. That I can give you.

Mr. ROBINSON. Just supply that for the record.

Dr. CHAFETZ. I am sorry I misunderstood that. We will supply it for the record.

[The information follows:]

MEDICALLY ORIENTED ALCOHOL RESEARCH

Of the 106 alcoholism research investigations supported by the National Institute of Alcohol Abuse and Alcoholism, approximately 50 percent are medically oriented, that is, dealing with diseases such as cirrhosis of the liver, pancreatitis, delirium tremens, nutritional diseases, and others. Another 20 percent are rehabilitation—or treatment—oriented, for example, studies on treatment techniques and methodologies, studies on utilization of proven therapies, and sociological studies to define the organization structures needed to provide these effective techniques, such as continuity of care, coordination of services, and adequate referral services for alcoholic persons. The remaining 30 percent deal with prevention and education studies, and with basic biological and behavioral research.

IMPLEMENTATION OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

Mr. ROBINSON. On page 4 you mentioned a subject which is very important considering your intention of trying to promote community participation and the implementation in the States of the Uniform Alcoholism and Intoxication Treatment Act. What is the present status of the implementation of that act in terms of the number of States that have adopted this model legislation and those that are in the process and so forth?

Dr. CHAFETZ. Seventeen States have already adopted the Uniform Alcoholism and Intoxication Treatment Act or similar legislation. Nine more have it under active consideration. However, there is still the amendment to the Comprehensive Alcoholism Act that has been considered in both Houses of the Congress and is now—the differences between House and Senate versions having been resolved and passed by the Senate side—it is waiting a decision on the House side.

In the amendment is a specific provision that will authorize moneys to be supplied to those States that have adopted the act to help them implement its provisions. It is our considered opinion that if the legislation becomes law, as has historically been shown money will bring interest, respectability, and change. I should also note that the fiscal year 1975 budget request contains $7 million for planning grants to States to implement provisions of the uniform act.

Mr. Robinson. For the record would you list the 17 States, the 9 in which you think adoption is imminent?

Dr. Chafetz. I will be happy to, sir.

[The information follows:]

STATES WHICH HAVE ADOPTED, OR ARE CONSIDERING ADOPTING, THE "UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT" OR SIMILAR LEGISLATION

Passed uniform act or similar legislation

Alaska
Arizona
Colorado
District of Columbia
Florida
Hawaii
Kansas
Maine
Maryland
Massachusetts
Minnesota
Nevada
New Mexico
North Dakota
Oregon
Rhode Island
Washington

Under consideration

Alabama
Illinois
Iowa
Michigan
Nebraska
New Jersey
South Carolina
Virginia
Wisconsin

DRUG AND ALCOHOL FORMULA GRANT ALLOCATION

Mr. Robinson. On pages 71 and 73 of the justifications, I find some interesting figures with regard to the allocation for the formula grants for drug abuse and those for alcohol. Of course, I understand the increase in my home State of Virginia since there is a $10 million increase from 1974 to 1975 for drug abuse. But in the case of alcohol, the amount is the same and yet the funding is reduced. I wonder what has happened since last year that causes us to get less money rather than the same amount of money, since the amount is the same.

Dr. Egeberg. Apparently the population index and the poverty level indexes changed.

Mr. Robinson. This is reevaluated annually, is it?

Dr. Chafetz. Mr. Robinson, the formula by which the formula grant moneys are allocated to each State are done by a tripart formula, one part of which we are unhappy with but we have not been able to change. The formula is based on the population, per capita income, and the third thing, which we are striving for but have not achieved yet, to some embarrassment to the Institute, the need for alcoholism services in the State. So consequently we have been using, I believe it is, the population as two parts, and per capita income as one part. When there are population shifts, this has a distinct effect on the formula. There must have been a population shift in Virginia which brings about the approximate $8,000 change.

Mr. Robinson. It isn't significant, but I just wondered why it would occur.

Finally, for the record, to the extent that your Institutes that are represented here support research and public information efforts in Virginia, would you identify them in the record for me, please?

Dr. Egeberg. All of the Institutes?

Mr. Robinson. Yes.

[The information follows:]

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
ACTIVE RESEARCH AND INFORMATION PROJECTS IN THE STATE OF VIRGINIA

	Institution	Title	Amount of Current Award
National Institute of Mental Health: Research:	Human Resources Research Organization, Alexandria, Virginia	"Assessing Relevance of Indirect Services in Schools"	$126,943
	Virginia Polytechnical Institute and State Univ. Blackburg, Virginia	"Social Effect in a Choice Reaction Time Paradigm"	5,998
	"	"Estimating the Relationship Between Abstract Variables"	7,080
	University of Virginia Charlottesville, Va.	"Brain Mechanisms and Behavioral Arousal"	36,450
	"	"Psycholinguistic Investigations"	18,168
	"	"Circadian Patterns of Normal and Pathological Functions"	28,998
	"	"Multiple Factors in the Control of Ingestion"	21,293
	"	"Neural Control of Feeding"	6,127
	Walter Riese (individual) Glen Allen, Virginia	"The Legacy of Phillippe Pinel"	3,000
	National Institute of Applied Behavioral Sci. Rosslyn, Virginia	"Developmental Approach to Community Change"	131,332
Subtotal			385,389

Note: There are no NIMH information projects based in the State of Virginia.

National Institute of Drug Abuse: Research:	Virginia Commonwealth Univ., Richmond, Va.	"Effects of Acute and Chronic Methadone Treatment"	116,405

	Institution	Title	Amount of Current Awar
National Institute of Drug Abuse: Research: (Cont'd)	Virginia Commonwealth Univ. Richmond, Virginia	"Cholinergic Systems in the Action of Drugs of Abuse"	97,746
	"	"A Multidisciplinary Study of Drugs of Abuse"	630,330
	"	"Pharmacology of Two Active Principles of Marihuana"	59,034
	"	"Stimulation Produced Analgesia: Addictive Properties"	5,945
	"	"Analgesia, Narcotic Action, and Pain Perception"	108,136
	Dot Systems Vienna, Virginia	"Provide Technical Assistance in Drug Development	50,000
Subtotal			1,067,596

Note: There are no drug abuse information projects based in the State of Virginia

National Institute on Alcohol Abuse and Alcoholism: Research:	Medical College of Va. Richmond, Va.	"Cerebro-Antonomic Changes by Ethanol and Ataractics"	36,653
Information:	General Electric Co. Arlington, Virginia	"Administration of the National Clearinghouse on Alcohol Information"	2,532,604
Subtotal			2,569,257
Total, Alcohol, Drug Abuse and Mental Health Administration			4,022,242

Mr. **Flood.** Mr. Patten.

COVERAGE UNDER NATIONAL HEALTH INSURANCE PROPOSALS

Mr. **Patten.** Thank you, Mr. Chairman.

We are intensely interested in the new national insurance. The morning paper says Kennedy and Mills got together and come a little bit closer. I haven't had time to digest it, but I can tell you back home this is the bread and butter issue which I feel deeply as people talk to me. This they hope will solve the crunch about not being able to pay their medical bills.

At best can this insurance program supply coverage for outpatients and inpatients and partial hospitalization service at our community health facilities?

Dr. **Egeberg.** Speaking of mental health or alcoholism or drug abuse?

Mr. **Patten.** At our little facility, for which we thank you at HEW, we take them all. We have drug addicts and the alcoholics. Generally it is mental health.

I am just wondering if they are going to get any help under the proposed National Health Insurance Act. Have you fellows been in there fighting?

Dr. **Egeberg.** Yes, we have been in there fighting and they have been very cooperative. We have had a number of meetings. I am not sure of the final proportion, but at one time it was one month hospitalization for mental health problems or two months of partial hospitalization. The proposed coverage for outpatient treatment in a community mental health center is the dollar equivalent of 30 visits to a private psychiatrist. These are really tremendous steps compared to what has been before.

I believe, and I would have to defer to Mr. Miller here, that this is still under consideration.

Mr. **Miller.** I can't go over every one of those figures, but our comprehensive health insurance proposal is before the Congress and does have all of those mental health features in.

Mr. **Patten.** It does?

Mr. **Miller.** Yes, it does.

Dr. **Egeberg.** Dr. Brown has some of this in front of him.

Dr. **Brown.** One way of getting at this, just common sense, is how much of the bill would it cover in people now treated by centers. It would take care of about 80 to 85 percent of the inpatient care now being provided in those 600 centers. The administration proposal would take care of almost all the day-care costs and it would take care of a good chunk of outpatient costs.

Mr. **Flood.** You are talking about the administration proposal?

Dr. **Brown.** Right.

Mr. **Flood.** There is the administration proposal, the original Kennedy proposal, and now the compromise between Kennedy and Mills.

Mr. **Patten.** Actually 60 plans originally.

Mr. **Flood.** They run pretty much in those three groups.

COVERAGE FOR PREVENTIVE EDUCATION UNDER CHIP

Dr. **Brown.** The point I wanted to make is the administration proposal does a pretty good job in covering most of the acute care. What it doesn't cover in any of the plans is the thing nobody wants to pay the bill for the preventive public health program, preventive education getting together with the juvenile court officers, the police, and the welfare workers. That is not the medical care. At this point we are trying to figure out some way the nonpatient oriented part of the bill can get paid. That is not solved.

Mr. **Patten.** I am told the community health service is very good. I hear the doctors, social workers, and also the educational workers agree.

You have a boy 16 that is a little problem child and get his mother and father with their limited education in there and get the benefit of the consultation and education and there is a vast improvement in the home. Thus we can see the results. Everybody claims we need the consultation and educational work.

I am just wondering whether the administration had any thoughts on how to fund it? I am glad to see you are raising the question yourself. I know Dr. Brown, you will have the answers. You will have a few people on your side when you come up with the answers. Actually I feel it is very important.

STATE AND LOCAL FUNDING OF MENTAL HEALTH PROGRAMS

You say now we have shown them how to do it the State and local governments will take over. I thought that was a beautiful paragraph—"they will be absorbed by the regular health service delivery systems."

We had a little donnybrook last week getting our senior citizens out. We had the Presbyterian minister and a prominent businesswoman volunteer. The hospitals cook the meals. And I had 90 meals delivered in volunteer automobiles. We feed them a hot meal at noon and give them a little of that loving care.

They had a little money out of the Model Cities. They were told they were finished. We thought we would go to the mayor and get a couple of dollars from revenue sharing. In last week's paper the president of the council says we will be revenue sharing to stabilize the tax rate. My senior citizens new lunch program is not going to get a nickel from the town hall.

I am not saying this critically because they have had a big problem on tax base. But I don't think our city and many other cities will finance the free lunch.

I was in the State government and well remember in 1957 for the first time we had 30,000 people in State mental institutions in mere custody. We proposed $10 million for research so we may get some better interns. The big issue was were we to have income tax or not. In the Governor's campaign the fellow running for Governor on one ticket was head of the appropriations committee, and brother, did he abort those budgets. The $10 million for research that we struggled so hard for in the legislature was gone. We never had a crack at it because he is running for Governor, let him be the boss. When he got through there was no $10 million for research.

If you want to go the State route on these programs, you go. I have 40 years experience, and I tell you, Doctor, that I am proud to sit here and say the first medical school ever built in the State of New Jersey was just finished at the State University, and it is beautiful, and the medical library as a result of Federal moneys.

ALCOHOLISM PROGRAM AT RUTGERS UNIVERSITY

We have an alcohol project at Rutgers. I happen to know it is doing a good job. You gave our local hospital a few dollars. Now we dry out the alcoholic for 5 days.

I don't know if you know what they are doing, and I don't know any answers and I don't think you do either. I know one thing, if a drunk takes a milk bottle and hits the wife over the head, instead of throwing him in the local jail you send him to the hospital, lock him up 5 days, dry him out—try to give him religion, try to get him in the AA I think that 5 day waiting period is something as against nothing. Right?

Dr. **Egeberg**. Yes, sir.

Mr. **Patten**. Do you know what we collect from alcohol taxes? $10 billion. When I was 10 years old, I was confirmed and I took the pledge with the bishop I would not drink and had to join the temperance society and swear alcoholic liquor wouldn't go over my lips until I was 18 years old. And I saw prohibition come in 1918 and that was some period. It tore this country apart as a moral issue. I will never forget the candidates for Congress fencing in 1927–28 whether they were for or against prohibition, and Roosevelt said we should repeal it, and prohibition was repealed.

One of the best series on the television, it ran last night, is the Untouchables. They are the movies of bootleggers in Chicago. Walter Winchell was narrator.

Dr. **Egeberg**. I voted with Al Capone once.

Mr. **Patten**. Surveys show the people turn to see the Untouchables. I know I make down here 325 receptions. The way we live as Americans we set up a bar and give some cheese and a few crackers, but the bar is the attraction. I think we collect billions and billions of dollars in alcohol taxes.

Dr. **Chafetz**. $10 billion a year.

DEATHS RELATED TO ALCOHOLISM OR ALCOHOL ABUSE

Mr. **Patten**. As to the other costs, you can't measure them. I know from our State doctors long ago I was told we are killing people by autos at the rate of 1,000 a week, 54,000 a year in this country. And alcohol is a factor. I won't mention a percentage but let's say in over 50 percent of the cases alcohol is a factor. So the cost to the American people, the cost to Russia, to Germany, the cost all over the world is enormous.

Doctor, I am going to tell you something. I was chairman of the Salvation Army Advisory Board in my town for 35 years. Men were sent there from 50 miles around. Somebody becomes a drunk, and the family doesn't want him. The chief of police says go to Perth Amboy to the Salvation Army. We had 94 men in there.

I just say to you men I am grateful for what you have done at Rutgers. I am grateful for the little project we have at Perth Amboy Hospital which everybody says is good. If we only hold them 5 days, that is good. But we are not really solving the problem.

SOCIAL PROBLEMS RELATED TO ALCOHOL ABUSE

Old towns like ours that have old housing inherit all the social ills. Don't give me 3 percent. If you want to measure my town I will break that record. When people have trouble and can't work and can't live, they look for cheap housing. I inherit the social problems in my town because I have the YMCA, I have the Hadassah, the Salvation Army, St. Peter and Paul. You get old clothes by walking in. They can't do it in the lovely suburbs. So the center of town inherits the social problems of the entire area.

My expenses are altogether different in trying to get a job done. I just wanted you to know it is a big problem you are talking about, not only in alcohol but mental health. Mental health is our No. 1 disease.

I want that consultation, I want that education, I want this other money in these budgets. That is how I see the problem. Don't give me this 3 percent.

I don't know about the gentleman from rich Virginia, but I know in our city we have more than 3 percent. We inherit all of their social ills, and we need this money. The mayor isn't going to give it to us out of revenue sharing. I want to thank you and praise you for the work you have done in the last 5 years, Dr. Brown and others. It is all good. I am happy I voted for it, but I want to vote for more.

I think we have to do a better job if we are going to collect billions of dollars in taxes and we are going to live with cocktail parties. That is how we live.

Dr. EGEBERG. We shall certainly keep what you say in mind and I think Dr. Brown has already made some notes to that effect.

Mr. ROBINSON. Since the gentleman insists on referring to Virginia, may I refer briefly to what he said. I just want to mention the fact that New Jersey has not inherited all of its social ills from Virginia.

But seriously for a moment I would like to refer to a question which I forgot, Doctor.

Mr. FLOOD. I thought we settled that war once.

HEALTH HAZARD WARNINGS ON ALCOHOLIC BEVERAGES

Mr. ROBINSON. It is this: We spend a great deal of our time today discussing the ravages of alcohol, and we know we have legislation that puts warnings on a pack of cigarettes to the effect there is a health hazard there.

Obviously there is a health hazard from alcohol too. I represent people that are over 18 that have religious beliefs that are continually inquiring of me, with regard to alcohol and its nonuse, as to why we don't have similar warnings on alcoholic beverages.

I would like for you to react to that in the record and your consideration of that issue in order that I can properly reply to them.

[The information follows:]

WARNING LABELS ON ALCOHOLIC BEVERAGES

The National Institute has a mandate to conduct its own research and to fund other research on alcohol's effect on the mind and body. On the basis of this research and other findings, the National Institute does make recommendations to the proper governmental authorities. It is, however, not a regulatory agency and therefore does not have the legislative authority to require the attachment of warning labels to containers for alcoholic beverages. Furthermore, there has never been conclusive scientific evidence to indicate that the moderate, responsible use of alcohol is harmful in health. If the use of alcohol in moderate quantities is proven to be harmful to the future, as has been the case with cigarettes, the NIAAA will, of course, reevaluate its position.

The Food and Drug Administration, and the Treasury Department's Bureau of Alcohol, Tobacco, and Firearms, are currently drafting an order requiring a complete listing of contents on the label of all alcohol beverages sold in the United States. This is being done in the interest of providing consumers with information concerning the ingredients used in the manufacture of alcoholic beverages. Officials of these two Federal regulatory agencies have said the final regulation could be promulgated this year.

It should be emphasized that while the problems of alcohol abuse and alcoholism are a major concern of the Federal Government, we have resisted the temptation to oversimplify the relationship between the use of alcohol and alcohol problems. We know, for example, that there are cultures such as the Italian and the Chinese which use alcohol heavily, but in a responsible manner, and have almost no alcohol problems. This is, in part, why the Institute has always stressed the need for responsible drinking by those who choose to drink, as opposed to being either for or against drinking per se. In fact, some types of labeling might indeed add to the "forbidden fruit" aspect of alcohol, creating even more ambivalence about alcohol use and thereby adding to our society's alcohol problems.

Mr. PATTEN. Mr. Chairman, one second. We put all of our senior-citizen housing right down on 42d Street and Broadway. We got it right on the main stem where the old hotel was so these people can walk to the supermarket, go to bingo games, walk to church. Otherwise they would be cloistered, locked up, and would see nobody.

We have women who have a program to call an old person on the phone every day. Volunteers. It is worth a dime to subsidize. We have other programs.

You know how I spent New Year's Eve. I called 12 widows over 72. They were at my house. That is our New Year's. Old widows, good friends of mine.

Mr. FLOOD. Hearts and flowers is a great number, but let's get back to appropriations. This may bring you in, Charlie.

LEGALITY OF MULTIYEAR FUNDING

We understand you are using this multiple-year funding procedure. In the current fiscal year now, the obligation is $106,265,000 that was appropriated for alcoholism project grants. Is that right?

Dr. EGEBERG. We were.

Mr. FLOOD. What I want to know, is that legal?

Dr. EGEBERG. I think I told you earlier this is all up for reconsideration when we found it may not be legal, but that was just found out within the last week.

Mr. FLOOD. You found out it wasn't legal during the last week. I don't have the citation, but I remember and so do you; we know about this, too—on the question, didn't a Federal court order on the impoundment of funds, let me quote from the language of the court. "To approved applicants under terms and conditions and for such time periods as usual and normal prior to February 1973."

What was the time period that was usual and normal prior to February 1973?

Mr. Miller. That is the whole issue, Mr. Chairman. That is not yet determined. As I understand the situation, the budgets that we have proposed in 1973, 1974, and 1975 are assuming multiyear funding of 1973 funds for alcoholism project grants. We have not obligated the money; we will not obligate it until we have this legal issue clear.

Mr. Flood. Hasn't the traditional procedure been to approve projects for more than 1 year but to fund them for only 1 year? What about that?

Mr. Miller. That is the majority by far, but we have many previous examples of multiyear funding. I happen to have the figures, which I will be glad to provide for the record, for 1970, 1971, and 1972.

CONGRESSIONAL INTENT TO FUND FOR A SINGLE YEAR

Mr. Flood. But isn't this multiple year funding procedure clearly contrary to both the congressional intent and that court order?

Mr. Miller. You can comment on the congressional intent better than I. As I mentioned when we were discussing NIH, we have a year like we never had before.

Mr. Flood. That is the under understatement of the hearing. Go ahead.

Mr. Miller. We didn't spend the 1973 money in 1973. So we have that huge amount to spend in 1974. We have the whole 1974 appropriations to spend all in 1 year. Now, if we spend it all on 1-year projects, we are going to create a continuation level in 1975 which is going to up this budget by a lot more than it is now. It would cost us $48 million more than we currently have in the budget, in fiscal year 1975 to 1-year fund our 1973 alcoholism projects. It just seems to create a program plateau we can't cope with in 1975.

Mr. Flood. These are all emotional subjects, alcoholism and mental health. These are all emotional and strictly God country and Yale here all day. The fact is we have an appropriation problem and it is a very tough one right now. This week you find out about the law.

What is the dollar value of the alcoholism grants which have been approved but can't be funded because of this multiple year procedure? That is a murder case.

Dr. Chafetz. I would like to respond, Mr. Chairman. At the time that the money was released and the appropriation became available we examined two factors. One was the desire to respond to the clear intent of the Congress and the court to obligate money, and at the same time not to destroy the quality and integrity of the alcoholism programs we were supporting.

At that time we also had a legal opinion from the Office of General Counsel that we could multiyear fund.

Mr. Flood. Thereby hangs the tale.

Dr. Chafetz. Yes, sir, but that tale has been shortened itself. We have now a verbal opinion that perhaps there is some question as to the legality of it. At present our spending plan has not been decided upon. It would be erroneous for me to indicate what we were going to do until we had that legal clarification. But I would venture to guess if we had fulfilled our multiyear plan of funding we probably would have multiyear funded approximately half of our grants. I suspect that isn't going to take place, although I don't know.

Mr. FLOOD. Thank you very much.

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JUSTIFICATION OF THE BUDGET ESTIMATES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health

Amounts Available for Obligation 1/

	1974 Revised	1975
Appropriation..	$815,975,000	$692,162,000
Amount withdrawn (PL 93-192)........................	-9,567,000	—
Proposed supplementals*............................	-13,195,000	—
Subtotal, adjusted appropriation..................	$793,213,000	$692,162,000
Real transfer to:		
"Office of the Secretary, Health" for Department-wide reductions of Public Affairs...............	-164,000	—
Comparative transfers to:		
"Office of the Assistant Secretary, Health" for support of 4 positions and $89,000 for the Office of Regional Operations, 4 positions and $166,000 for the Drug Abuse Operations, and 6 positions and $158,000 for the OASH.............	-413,000	—
"National Institutes of Health" for support of 2 positions for the Financial Assistance Systems Branch..................................	—	—
"Departmental Management" $28,000 for reporting functions, 7 positions and $162,000 for support of positions transferred to Departmental Management and $7,000 for the Public Affairs Management Systems...............	-197,000	—
Comparative transfers from:		
"Departmental Management" for support of Regional Services and indirect cost negotiations functions..........................	+3,000	—
Office of the Assistant Secretary, Health" for support of salaries and expenses for Commissioned Officer Personnel..................	+37,000	—
"FDA, NIH, HRA, HSA, CDC, and OASH" for support of 5 positions for the Federal Employees Alcohol Program..............................	+138,000	—
Subtotal, budget authority..........................	792,617,000	692,162,000

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	1974 Revised	1975
Unobligated balance, start of year..................	+$31,879,000	+$200,000
Unobligated balance, lapsing........................	-2,921,000	---
Unobligated balance transferred to:		
"District of Columbia Government"................	-6,427,000	---
Unobligated balance transferred from:		
"Buildings and Facilities, HSMHA"................	+6,627,000	---
Unobligated balance, end of year....................	-200,000	---
Total, base obligations..........................	821,575,000	692,362,000
Unobligated balance restored........................	+139,882,000 2/	---
Total, obligations.............................	961,457,000	692,362,000

1/ Excludes $140,000 for reimbursement activities carried out by this account in 1974.

2/ Excludes comparative transfer of $8,027,000 to NIH for General Research Support Grants

* Pay raise transfer

Summary of Changes

1974 Estimated obligations................................	$961,457,000
1975 Estimated obligations................................	692,362,000
Net change................................	-269,095,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. One extra day of pay...............			---	+160,000
2. Within-grade increases.............			---	+409,000
3. Annualization of 1974 pay raise....			---	+366,000
4. Increased payments to other accounts:				
a. NIH Management Fund...........			---	+666,000
b. Health, Service and Supply Fund			---	+117,000
5. Increase in payments to Bureau of Employees' Compensation............			---	+15,000
6. Increased postage charges..........			---	+657,000
7. Increased Federal tele-communication service charges...............			---	+153,000
Subtotal...			---	+2,543,000
B. Program:				
1. General Mental Health Community Programs:				
a. Staffing......................	---	155,513,000	---	+16,540,000
b. Children's Services...........	---	19,000,000	---	+7,844,000
2. Drug Abuse:				
a. Research Grants and Contracts..	---	18,768,000	---	+4,355,000
b. Community Programs, Grants to States......................	---	25,000,000	---	+10,000,000
c. Management and Information....	227	15,571,000	+71	+1,065,000
3. Alcoholism:				
a. Management and Information.....	91	11,245,000	+16	+240,000
4. Buildings and Facilities..........	---	---	---	+200,000
5. Program Direction.................	290	9,146,000	---	+1,702,000
Subtotal...			+87	+41,946,000
Total, increases...			+87	+44,489,000

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	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Decreases:				
A. Built-in:				
1. Annualization of 1974 Employment Reduction			---	-8,522,000
Subtotal			---	-8,522,000
B. Program:				
1. General Mental Health:				
a. Research Grants	---	82,819,000	---	-17,906,000
b. Training	---	128,021,000	---	-62,920,000
c. Community Programs, Construction	---	34,250,000	---	-34,250,000
d. Management and Information	383	23,163,000	-10	-3,908,000
2. Drug Abuse:				
a. Research Direct Operations	---	7,793,000	---	-162,000
b. Training	---	15,138,000	---	-5,169,000
c. Community Programs, Project grants and contracts	---	182,649,000	---	-60,649,000
d. Management and Information	---	15,571,000	---	-1,141,000
3. Alcoholism:				
a. Research grants and contracts	---	12,723,000	---	-2,793,000
b. Training	---	12,224,000	---	-10,277,000
c. Community Programs:				
(1) Project grants and contracts	---	106,265,000	---	-74,214,000
(2) Grants to States	---	75,600,000	---	-30,000,000
d. Management and Information	---	11,245,000	---	-1,673,000
Subtotal			-10	-305,062,000
Total, decreases			-10	-313,[illegible],000
Total, net change			+77	-269,095,000

Explanation of Changes

Increase :

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A. Built-in:

1. One extra day of pay: An increment of $160,000 will provide pay costs for an extra day of operations in 1975.

2. Within-grade increases: An increase of $409,000 will provide coverage for escalations in the cost of personal services resulting from normal periodic within-grade advances, to the extent that they are not offset by savings from employee turnover and employment reductions.

3. Annualization of 1974 pay raise: An increase of $366,000 will provide full year funding for the October 1973 pay raise.

4. Increased payments to other accounts: A total increase of $783,000 is requested to support central service costs provided to the Agency by the Health Service and Supply Fund ($117,000) and the National Institutes of Health ($666,000).

5. Increased payments to Bureau of Employees' Compensation: Payments to the Bureau of Employees' Compensation will increase $15,000 in 1975.

6. Increased postage charges: An increment of $657,000 is requested to cover increased costs of postage services provided to the Agency.

7. Increased Federal Telecommunication Service Charges: An increment of $153,000 is requested to cover increased costs of telephone services provided to the Agency.

B. Program:

1. General Mental Health, Community Programs:

a. Staffing: The increase of $16,540,000 will provide support for increased continuation costs for the Community Mental Health Centers Staffing grant program. No new awards will be made.

b. Children's Services: The increase of $7,844,000 is required for support of increased continuation costs in this program. No new awards will be made.

2. Drug Abuse:

a. Research: The increase of $4,355,000 will allow expansion of the research grants in the areas of narcotic antagonists, opiate substitutes, heroin addiction, and psychosocial and clinical studies.

b. Community Programs, Grants to States: The increase of $10,000,000 will improve the States' ability to assume responsibility for drug abuse programs.

c. Management and Information: The increase of $1,065,000 will be used to support 71 new positions in 1975, a portion of which will reflect the absorption of SAO positions.

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3. Alcoholism:

a. Management and Information: The increase of $240,000 will be used to support 16 new positions in 1975.

4. Buildings and Facilities: This increase will be used for the construction of a perimeter fence around the animal center in Poolesville, Maryland.

5. Program Direction: The increase of $1,702,000 will be used to pay building rental costs for buildings occupied by Agency staff.

Decreases:

A. Built-in

1. Annualization of the 1974 position reduction: - This results in a reduction of $8,522,000 in terms of obligational authority.

B. Program:

1. General Mental Health:

a. Research: The reduction of $17,906,000 includes decreases in budget authority of $5,625,000 for the grant program and $1,000,000 for the Hospital Improvement program. The remaining reduction of $11,281,000 results from the release of FY 1973 appropriated funds.

b. Training: A decrease of $34,933,000 in budget authority in the training program reflects the beginning of a phase-out of categorical training programs. Further Federal support of categorical training is inappropriate. The remaining decrease of $27,987,000 results from the fact that 1974 obligations included funds released from the 1973 appropriation.

c. Construction: The program decrease includes budget authority of $14,250,000 as well as $20,000,000 released from the FY 1973 appropriation.

d. Management and Information: Reduced programs levels in FY 1975 result in program decreases of 10 positions and $3,908,000.

2. Drug Abuse:

a. Research: The decrease of $162,000 reflects a decrease in operating funds in FY 1975.

b. Training: The decrease of $5,169,000 reflects the phasing-out of the training grant program. Further Federal support of categorical training is inappropriate.

c. Community Programs, Project grants and contracts: The program decrease of $60,649,000 in obligations, reflects lower continuation commitments in FY 1975. It also reflects a lower number of new awards. A total of 9 new awards will be made, compared with 76 in 1974. Of the funds carried over from FY 1973, $17 million will be obligated in FY 1974 to fund FY 1975 continuation commitments.

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d. Management and Information: A program reduction of $1,141,000 in operating funds will be necessary.

3. Alcoholism:

a. Research: Although there is an increase for this activity in terms of budget authority of $1,907,000, the obligation level decreases by $2,793,000 in FY 1975. The decrease is caused by the fact that FY 1974 obligations include funds released from FY 1973. Full funding of multi-year awards will be utilized to obligate these released funds. A total of 57 new awards will be made from these funds at a cost of $1,900,000. Thirty-one of these awards will receive multi-year funding to provide two additional years of support.

b. Training: The overall decrease includes $4,377,000 in budget authority as well as $5,400,000 released from the 1973 appropriation. Full funding of multi-year awards will be utilized to obligate these funds. Of the total released from 1973, $1,800,000 will fund the first-year costs of 30 grants, while the remaining $3,600,000 will fund their remaining two years of committed support.

c. Community Programs, Project grants and contracts: The program decrease includes $34,905,000 in budget authority, as well as $39,309,000 obligated in 1974 from the 1973 appropriation. Full funding of multi-year awards will be utilized to obligate these released funds. Of the $39,309,000, $12,837,000 will fund the first year cost of 83 projects, while $25,672,000 will fund their remaining two years of committed support. The remaining $800,000 will fund [illegible] staffing grants for their initial year of support.

d. Community Programs, Grants to States: There is a program decrease of $3[illegible],000 in obligational authority. This results from the fact that $3[illegible],000 was released from the FY 1973 appropriation and will be obligated in FY 1974.

e. Management and Information: This includes a program reduction of $[illegible],000 in operating funds as well as $1,2[illegible],000 from 1973 released funds.

Obligations by Activity

Page Ref.		1974 Base*		1975 Estimate		Increase or Decrease	
		Pos.	Amount	Pos.	Amount	Pos.	Amount
	General Mental Health:						
19	Research..............	330	$90,146,000 (101,427,000)	330	$84,468,000 (84,468,000)	---	-$5,678,000 A/ (-16,959,000)
26	Training..............	---	100,034,000 (128,021,000)	---	65,101,000 (65,101,000)	---	-34,933,000 B/ (-62,920,000)
29	Community Programs:						
	Construction of Centers............	---	14,250,000 (34,250,000)	---	--- (---)	---	-14,250,000 C/ (-34,250,000)
	Staffing of Centers.	---	155,513,000	---	172,053,000	---	+16,540,000 D/
	Mental Health of Children...........	---	19,000,000	---	26,844,000	---	+7,844,000 E/
31	Management & Information.............	383	23,163,000	373	16,753,000	-10	-6,410,000 F/
	Subtotal............	713	402,106,000 (461,374,000)	703	365,219,000 (365,219,000)	-10	-36,887,000 (-96,155,000)
	Drug Abuse:						
33	Research..............	108	34,056,000	108	34,000,000	---	-56,000 G/
36	Training..............	---	15,138,000	---	9,969,000	---	-5,169,000 H/
37	Community Programs:						
	Project grants & contracts..........	---	182,649,000	---	122,000,000	---	-60,649,000 I/
	Grants to states....	---	25,000,000	---	35,000,000	---	+10,000,000 J/
40	Management & Information	227	15,571,000	298	15,646,000	+71	+75,000 K/
	Subtotal............	335	272,414,000	406	216,615,000	+71	-55,799,000
	Alcoholism:						
43	Research..............	6	8,489,000 (13,189,000)	6	10,405,000 (10,405,000)	---	+1,916,000 L/ (-2,784,000)
44	Training..............	---	6,824,000 (12,224,000)	---	1,947,000 (1,947,000)	---	-4,877,000 M/ (-10,277,000)
45	Community Programs:						
	Project grants & contracts..........	---	66,956,000 (106,265,000)	---	32,051,000 (32,051,000)	---	- 34,905,000 N/ (-74,214,000)

Obligations by Activity (Continued)

Page Ref.		1974 Base*		1975 Estimate		Increase or Decrease	
		Pos.	Amount	Pos.	Amount	Pos.	Amount
	Alcoholism						
	Grants to states....	---	$45,600,000 (75,600,000)	---	$45,600,000 (45,600,000)	---	--- (-30,000,000)
48	Management & Information	91	10,040,000 (11,245,000)	107	9,863,000 (9,863,000)	+16	-177,000 O/ (-1,382,000)
	Subtotal...........	97	137,909,000 (218,523,000)	113	99,866,000 (99,866,000)	+16	-38,043,000 (-118,657,000)
50	Buildings & Facilities..	---	---	---	200,000	---	+200,000 P/
51	Program Direction.......	290	9,146,000	290	10,462,000	---	+1,316,000 Q/
	Total Obligations(bases)	1,435	821,575,000	1,512	692,362,000	+77	-129,213,000
	Total Obligations.......		(961,457,000)		(692,362,000)		(-269,095,000)

*1974 Base - Excludes 1973 appropriations restorations

Total obligations shown in parenthesis.

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Explanation of Changes (by activity)

General Mental Health:

A. Research - The decreases of $5,625,000 for regular research grants and $1,000,000 for Hospital Improvement grants are offset by mandatory increases of $947,000 for Intramural Research activities.

B. Training - Training grants and fellowships are reduced by $34,933,000 reflecting the phasing-out of categorical training.

C. Construction of Centers - No additional funds have been requested in FY 975.

D. Staffing of Centers - The increase of $16,540,000 will provide funds for additional continuation costs for centers initially funded in FY 1974.

E. Mental Health of Children - The increase of $7,844,000 will provide funds for additional continuation costs. No new funds will be awarded.

F. Management and Information - This decrease reflects built-in reduction of $2, 02,000. In addition, 10 positions and $3,906,000 in operating funds have been eliminated in 1975 as a result of reduced program levels.

Drug Abuse:

G. Research - This reflects an increase in research grants of $4,335,000 which is offset by built-in decreases resulting primarily from the transfer of Lexington CRC to the Bureau of Prisons.

H. Training - This reduction of $5,169,000 results from the phasing-out of the training grant program.

I. Project Grants and Contracts - The reduction of $60,649,000 reflects funding levels for continuation commitments required to maintain current treatment capacity. Grants totaling $17 million were funded in 1974 to pay a portion of these FY 1975 costs.

J. Grants to States - This increase of $10,000,000 will improve the States' ability to assume responsibility for their own drug abuse programs.

K. Management and Information - Additional funds totaling $1,216,000 are included to cover mandatory increases and the cost of 71 new budgeted positions. These increases are partially absorbed by program reductions in other areas.

Alcoholism:

L. Research - This reflects an increase in research grants and contracts of $1,907,000. The remaining $9,000 is a mandatory increase for employees of the Alcohol Intramural Research Program.

M. Training - This reduction of $4,877,000 reflects a phasing-out of training programs.

N. Community Programs, Project grants and contracts - This reduction of $34,905,000 primarily reflects a decrease of 292 projects requiring continuation support in FY 1975, as well as a reduction in the number of new awards.

O. Management and Information - Additional funds are included for mandatory changes and to cover the cost of 16 new positions. The increases are more than offset, however, by program reductions in other areas.

P. Buildings and Facilities - This increase of $200,000 will be used to construct a perimeter fence around the animal center in Poolesville, Maryland.

Q. Program Direction - This overall increase of $1,316,000 includes $1,70 ,000 for building rental costs, offset by built-in decreases.

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Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Total number of permanent positions..	1,435	1,512	+77
Full-time equivalent of all other positions..........................	343	334	-9
Average number of all employees......	2,139	1,795	-344
Personnel compensation:			
Permanent positions................	$31,579,000	$27,038,000	-4,541,000
Positions other than permanent.....	2,773,000	2,636,000	-137,000
Other personnel compensation.......	617,000	531,000	-86,000
Subtotal, personnel compensation	34,969,000	30,205,000	-4,764,000
Personnel benefits..................	3,437,000	3,013,000	-424,000
Travel & transportation of persons.	2,528,000	2,381,000	-147,000
Transportation of things...........	203,000	185,000	-18,000
Rent, communications & utilities...	2,423,000	4,646,000	+2,223,000
Printing and reproduction..........	1,111,000	1,070,000	-41,000
Other services......................	18,486,000	19,293,000	+807,000
Project contracts................	75,735,000	70,136,000	-5,599,000
Supplies and materials.............	2,203,000	1,843,000	-360,000
Equipment..........................	2,002,000	1,869,000	-133,000
Grants, subsidies & contributions..	818,360,000	557,721,000	-260,639,000
Total obligations by object........	961,457,000	692,362,000	-269,095,000
Total obligations excluding 1973 appropriation.................	821,575,000	692,362,000	-129,213,000

Authorizing Legislation

	1975	
Legislation	Authorization	Appropriations Requested
Public Health Service Act, Section 301/302/303		
Research Grants and Contracts	Indefinite	$105,461,000
Training grants and contracts	Indefinite	69,543,000
Drug Abuse Community Programs, Grants and Contracts	Indefinite	600,000
Direct Operations	Indefinite	76,136,000
Section 314 e Alcohol Project Grants & Contracts	2/	21,000,000
Community Mental Health Centers Act: Part B, Sec. 224 - Continuation Grants for Staffing of CMHC's	Sums necessary	172,053,000
Part E, General Provisions Section 261 - Authorization of Appropriations for Rehabilitation of Alcoholics, Narcotic Addicts, and other Persons with Drug Abuse and Drug Dependence Problems:		
Continuation of Section 242 Alcohol Staffing Grants	Sums necessary	11,051,000
Continuation of Section 251 Drug Staffing Grants	Sums necessary	14,374,000
Part F, Section 271 Continuation of Staffing Grants for Child Mental Health Treatment Facilities	Sums necessary	26,844,000
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970: Title III, Part A, Section 301 - Formula Grants	1/	45,600,000
Drug Office and Treatment Act of 1972:		
Section 401, Community Mental Health Centers Act	60,000,000	—
Section 409, Formula Grants	45,000,000	35,000,000
Section 410, Special Project Grants & Contracts	160,000,000	113,300,000
Narcotic Addiction and Rehabilitation Act of 1966: Title VI, Miscellaneous Provisions, Section 607, Authorization of Appropriations	Sums necessary	1,200,000

1/ Authorization expires June 30, 1974: additional authorizing legislation is proposed.

2/ Legislation to be proposed to incorporate alcohol project grants and contracts into Section 314e of the Public Health Service Act.

Alcohol, Drug Abuse, and Mental Health

Appropriations History

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1963	$126,899,000	$133,599,000	$148,599,000	$143,599,000
1964	190,096,000	177,288,000	190,096,000	183,288,000
1965	224,085,000	223,273,000	223,273,000	223,273,000
1966	278,669,000	278,669,000	283,169,000	283,169,000
1967	305,115,000	310,119,000	315,619,000	315,619,000
1968	346,909,000	296,909,000	346,909,000	346,909,000
1969	364,939,000	342,439,000	364,939,000	350,439,000
1970	357,904,000	360,302,000	385,000,000	360,302,000
1971	346,656,000	371,738,000	456,738,000	389,238,000
1972	499,451,000	581,201,000	658,201,000	612,201,000
1973	603,719,000	803,823,000	911,525,000	808,823,000
1974	1,281,731,000	795,475,000	845,475,000	815,975,000 1/
1975	692,162,000			

1/ Includes $26,874,000 which may be withheld in accordance with Public Law 93-192.

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Justification

Alcohol, Drug Abuse, and Mental Health Administration

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos	Amount	Pos	Amount	Pos	Amount
Personnel Compensation & Benefits	1435	$38,406,000*	1512	$33,218,000	+77	-5,188,000
Other Expenses	--	783,169,000	--	659,144,000	—	-124,025,000
Total, Obligations	1435	821,575,000* (961,457,000)	1512	692,362,000	+77	-129,213,000 (-269,095,000)

GENERAL STATEMENT

The basic mission of the Alcohol, Drug Abuse, and Mental Health Administration is to develop knowledge, manpower, and services to prevent mental illness, to treat and rehabilitate the mentally ill, and to prevent the abuses of drugs and alcohol.

The Agency's FY 1975 budget request portrays this mission in both programmatic and functional terms. Programmatically, the appropriation is divided according to its three major areas of responsibility: general mental health, drug abuse, and alcoholism. Each of these broad programmatic areas is, in turn, divided functionally into research, training, and services. Within each function, priorities, needs, and approaches to these needs are addressed in specific programmatic terms.

The budget request reflects significant changes in both the training and services functions. In training, categorical support is recommended for phase-out. It is felt the mental health training programs, including drugs and alcohol, have developed to a point that they are now able to compete in the open market for funds, particularly in those professional fields for which there is a relatively high earning potential. Accordingly, no new awards will be initiated, except for the research fellowship program established in FY 1974.

The budget request for service programs reflects the philosophy that the Federal role should be limited to demonstrating the feasibility of service models and techniques rather than providing direct patient care. As a result, programs authorized by the Community Mental Health Centers Act are being recommended for phase-out. Greater reliance will be placed on income from third party payments, and state and local contributions, for continued future support of these programs. Accordingly, new Federal funds for drug abuse and alcoholism will be used to support planning grants to States and to fund demonstration models to develop new or improved treatment techniques.

The FY 1974 and FY 1975 funding levels proposed for the Agency's major program areas are set forth in the following table:

	1974 Base	1975 Estimates	Increase or Decrease
General Mental Health	$402,106,000	$365,219,000	-$36,887,000
Drug Abuse	272,414,000	216,615,000	-55,799,000
Alcoholism	137,909,000	99,866,000	-38,043,000
Buildings & Facilities	--	200,000	+200,000
Program Direction	9,146,000	10,462,000	+1,316,000
Total	$821,575,000	$692,362,000	-$129,213,000

* Excludes 1973 appropriation restoration.

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I. General Mental Health

	1974 Base*		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...........	713	$20,716,000	703	$17,746,000	-10	-$2,970,000
Other expenses...........	---	381,390,000	---	347,473,000	---	-33,917,000
Total...................	713	402,106,000	703	365,219,000	-10	-36,887,000

Authorization:

Research: Public Health Service Act, Sections 301 and 303;
Training: Public Health Service Act, Sections 301, 303 and 433;
Community Programs: Community Mental Health Centers Act
  Construction: Section 201
  Staffing: Section 224
  Mental Health of Children: Part "F", Section 271
Management and Information: Public Health Service Act, Sections 301 and 303.

This major grouping of activities encompasses all programs of the National Institute of Mental Health. The 1974 and 1975 funding levels for the Institute's major program areas are set forth in the following table:

	1974 Base*	1975 Estimate
Research...................	$90,146,000	$84,468,000
Training...................	100,034,000	65,101,000
Community programs.........	188,763,000	198,897,000
Management & Information..	23,163,000	16,753,000
Total obligations.......	402,106,000	365,219,000

Narrative

Funds included in these activity categories support the programs and operations of the National Institute of Mental Health (NIMH). NIMH provides leadership, policies and goals for the Federal effort in the promotion of mental health and the prevention and treatment of mental illness. In carrying out these responsibilities, NIMH (1) conducts and supports research on the biological, psychological, sociological, and epidemiological aspects of mental health and mental illness; (2) supports the training of professional and paraprofessional personnel in the promotion of mental health and the prevention and treatment of mental illness; (3) conducts and supports research on the development and improvement of mental health services delivery, administration and financing, and supports mental health service programs and projects; (4) collaborates with and provides technical assistance to state authorities and regional offices, and supports state and community efforts in planning, establishing, maintaining, coordinating and evaluating more effective mental health programs; (5) collaborates with, provides assistance to, and encourages other governments, agencies and institutions to promote mental health programs; and (6) provides information on mental health and illness to the public and to the scientific community.

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* Excludes $59,268,000 in 1973 appropriation restoration.

A. General Mental Health Research: The purpose of the research program is to develop new knowledge and approaches to the causes, diagnostic treatment, control and prevention of mental illness through basic, clinical and applied research. This activity supports the NIMH research grants; the hospital improvement and research career programs; and operation of the intramural research program which is conducted in the Institute's own laboratories and clinics. Funding for this activity, and descriptions of the major program components, are set forth in the material which follows:

	1974 Base*		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants, subsidies and contributions........	--	$71,538,000	--	$64,913,000	--	-$ 6,625,000
Intramural research:						
Personnel compensation & benefits....	330	8,656,000	330	8,937,000	--	+281,000
Other objects.......	--	9,952,000	--	10,618,000	--	+666,000
Total............	330	90,146,000	330	84,468,000	--	-5,678,000

1. Grants, subsidies and contributions: This category includes regular research grants, hospital improvement projects and the research career program:

	1974 Base*	1975 Estimate
Research grants..........	$61,172,000	$56,812,000
Hospital Improvement projects..................	5,900,000	4,900,000
Research career program...	4,466,000	3,201,000
Total..................	71,538,000	64,913,000

a. Research grants: These projects are authorized under Sections 301 and 303 of the Public Health Service Act. Grants are available to investigators affiliated with public or nonprofit agencies (including state, local or regional government agencies), research and academic institutions, hospitals and other organizations. Tables 1 and 2 show the distribution of research grant funds by type of grant and by program.

Table 1 - Distribution of Research Grants

	1974 Estimate		1975 Estimate		Increase or Decrease	
Type	No.	Amount	No.	Amount	No.	Amount
Continuation...........	558	$36,337,000	645	$49,412,000	+87	+$13,075,000
Competing renewals.. ..	141	8,123,000	107	5,650,000	-34	-2,473,000
New projects...........	199	14,712,000	--	---	-199	-14,712,000
Small grants..........	150	1,000,000	125	750,000	-25	-250,000
Supplementals..........	(39)	1,000,000	(39)	1,000,000	--	---
Total appropriations.	1,048	61,172,000	877	56,812,000	-171	-4,360,000
Obligations..........		(71,272,000)		(56,812,000)		(-14,460,000)

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* Excludes $11,281,000 in 1973 appropriation restorations.

Table 2 - Research Grants Program Distribution

Program	1974 Estimate	1975 Estimate	Increase or Decrease
Behavioral sciences.......	$17,932,000	$17,290,000	-$642,000
Clinical research.........	9,285,000	8,900,000	-385,000
Applied research..........	4,438,000	4,180,000	-258,000
Psychopharmacology........	11,795,000	11,300,000	-495,000
Epidemiology..............	1,727,000	1,672,000	-55,000
Services development......	8,125,000	7,125,000	-1,000,000
Crime & delinquency.......	3,738,000	3,045,000	-693,000
Metropolitan problems.....	1,868,000	1,400,000	-468,000
Minority mental health....	2,264,000	1,900,000	-364,000
Total appropriations....	61,172,000	56,812,000	-4,360,000
Obligations.............	(71,272,000)	(56,812,000)	(-14,460,000)

(1) Description of research grant programs: The program areas identified above are explained in the material which follows:

(a) The purpose of the behavioral sciences program is to stimulate and support research to develop an understanding of behavior - including both the psychological and social aspects. Included are studies of the brain and central nervous system, and their relationship to behavior; studies in general experimental psychology including such areas as learning, memory, perception and sensory/motor processes, and studies in the social psychologies such as culture and its effect upon personality and group behavior.

(b) Clinical research fosters studies designed to increase knowledge and improve methods of diagnosis, treatment and prognosis of mental illness. In clinical research, emphasis is placed upon studies leading to improved treatment methods, and the study of the combinations of biological, environmental and social factors from which mental illness and emotional distress may arise.

(c) The applied research program supports projects designed to increase understanding of contemporary social problems and problems related to the mental health of juveniles which are primarily associated with social and environmental conditions. It supports projects focused on experimentation and evaluation of interventions intended to produce change which will assist in the resolution of problems [illegible] promote the healthy growth of individuals.

(d) The Institute's psychopharmacology program has as its goals the increase of knowledge about the ways by which drugs influence thought, mood and behavior: stimulation of the development of new drugs and evaluation of their efficiency and safety; the non-pharmacologic factors which influence drug response; assessment of the impact of drug use on society; and dissemination of information on psychotropic drugs to foster research on the therapeutic usefulness of these agents in treating mental illness.

(e) The Institute's epidemiology program emphasized development of information systems on the status of mental health in communities and evaluation of the impact of programs upon these communities; child mental health; and longitudinal studies (i.e., continuing studies of the same population group).

(f) The services development program supports research to provide knowledge required for the effective utilization and development of increasingly complex service delivery systems. The integration of mental health services with allied delivery systems is a major priority of the Institute.

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(g) The Institute's crime and delinquency research program places major emphasis upon efforts to better understand and cope with the various forms of deviant behavior, whether such behavior is handled as mental illness or violations of the criminal law.

(h) Research in metropolitan problems involves investigation of the effects of modern urban life upon individual and collective mental health.

(i) The activities and aims of minority mental health research are to increase the quality and quantity of research for the Nation's minority groups, principally, Blacks, Indian-Americans, Spanish-Americans, and Asian Americans. Research is supported to understand the causes, results, and mechanisms of prejudice and discrimination, and to consider methods of correcting the attitudes and conditions which place minorities in a disadvantaged position. This is done with minority groups themselves playing a major role in design, administration, and conduct of the research.

(2) Institute priorities: Cutting across the programs described above are certain priority areas to which NIMH gives particular attention. Among these priorities are research efforts directed to the mental health of children, problems of the aging, crime and delinquency, and minority mental health problems. Adding still another dimension, and relating to all of these efforts, are specialized studies in the areas of schizophrenia and depression. NIMH efforts in these areas are summarized in the material which follows:

(a) Child mental health: NIMH is participating in department-wide initiative on child abuse and neglect. The Office of Child Development is the lead agency, and coordinates a special Department Committee on Child Abuse and Neglect. The primary NIMH role in the overall effort is to systematically increase knowledge about the mental health problems of child abuse and neglect, including development of new research studies to fill identified gaps in knowledge.

NIMH is currently supporting projects which address child mental health systems approaches, the study of alternate housing pattern systems, and the relationships between mental health and the schools. It has been found that in communities which consolidate their human services in a systems approach, there is increased effectiveness and reductions in duplications of efforts in the utilization of professional services. Since schools have control over children for approximately 20 percent of their waking hours from grades 1 through 12, changes in the school environment will fundamentally affect the whole social and learning environment of the child.

The emotional health and competence of the developing child is a major focus of NIMH endeavor. Studies directed at understanding how children become well adjusted and the factors which influence aggressive or hostile behavior are of high priority; there is special interest in the influence of television viewing on children's behavior. Since about 10% of all children suffer from learning disabilities, NIMH is supporting efforts directed at early identification and of appropriate treatment methods so that emotional difficulties related to this disability can be avoided.

(b) Aging: NIMH efforts now underway in the area of aging involve studies concerned with prevention of mental disorders among the aging, as well as finding methods to help those already impaired. These efforts include basic studies of biological mechanisms of aging, psychiatric illness in the aged, social, psychological and cultural influences related to adjustment in later life, and applied research demonstrating innovative methods of assisting older persons to continue to function.

(c) Depression: Recent NIMH research efforts have focused on psychobiology, in an attempt to determine the basic physiological factors underlying the abnormal behavior which is recognized as depression. NIMH is now supporting genetic studies seeking to understand the familial aspect of some depressive illnesses, suicide studies aimed at clarifying this tragic outcome of depression for some, and psychopharmacological studies aimed at discovering newer and more effective modalities of drug treatment. We are also involved in support of psychotherapeutic studies seeking to discover treatments for the milder forms of depression.

(d) Schizophrenia: Schizophrenia, although not a major cause of death, nevertheless ranks as one of our more serious national health problems. This is because of the number of people affected (nearly 2 million Americans now alive will have been hospitalized for schizophenia by the time they reach middle age), its long duration with onset early in life, often persisting for years; the loss of human potential and the sheer public cost variously estimated at several billion dollars annually.

More recently the advances in understanding the genetic bases for a major segment of this population, and notable progress in the technology of biological research generally, has opened the doors to new directions of work in these areas.

(e) Crime and Delinquency: NIMH is concerned with crime and delinquency insofar as such problem behavior also has relevance in terms of psychological functioning and mental health adaptation. Our specific interests in this field concern the development of better understanding, prevention, treatment and handling of various forms of deviant behavior. Programs of NIMH address these behavior forms, rather than use the legal definitions of the juvenile and criminal justice systems. However, considerable attention is given to the problem areas of common concern to the criminal justice and mental health fields. Among these issues of mutual concern are determinations of competency to stand trial, hospitalization of mentally disordered offenders, treatment and release programs for such offenders, and appropriate mental health and related programs for rape victims.

(f) Mental Health of Minorities: NIMH has attempted to increase knowledge of minority mental health problems through the establishment of a special Center for Minority Group Mental Health Programs. Fifteen national planning and follow-up conferences have been initiated by the Center for Minority Group Mental Health Programs (Black-2, Spanish-Speaking-3, Asian-American-4, and Native American-6). These national meetings have provided each of the minority groups with the opportunity to identify their primary concerns and make recommendations as to the mechanism appropriate to the resolution of these issues. This present need exists because of the failure and neglect of pre-existing program mechanisms to focus on these long neglected areas.

b. Hospital Improvement Program: Projects funded in connection with this program are authorized under Section 303(a)(2) of the Public Health Service Act. The program provides funds to state mental hospitals for projects which will improve the quality of patient services; encourage transition to open institutions; and develop relationships with community programs for mental health. There are no matching requirements, but grantees are required to pay a portion of the total project cost. Support to an institution may not exceed 10 years, and each hospital may not receive more than $100,000 in any one year. The following table shows the distribution of hospital improvement project grants by type:

Type	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations........	43	$4,158,000	49	$4,900,000	+6	+$742,000
Competing renewals...	9	885,000	--	---	-9	-885,000
New projects.........	9	857,000	--	---	-9	-857,000
Total appropriations.	61	5,900,000	49	4,900,000	-12	-1,000,000
Obligations..........		(6,900,000)		(4,900,000)		(-2,000,000)

The Hospital Improvement Program is directed toward improving the treatment, care and rehabilitation of the mentally ill in state-supported mental hospitals throughout the Nation. It is specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change and the development of relationships with community mental health programs. Funds are available through the grant mechanism for support of programs that are designed to explore and validate new methods of treatment, and to develop new knowledge.

At the end of June 1973, a total of 269 Hospital Improvement Program grants had been awarded to 186 state mental hospitals in the country.

During FY 1973, 73 grants were funded serving an average of 75 patients per institution for a total of 5,475.

A decrease of $1,000,000 in appropriations for Hospital Improvement projects is projected for 1975, representing the first step in the gradual phasing-out of the program. Since this program has achieved its goal of demonstrating innovative treatment methods in virtually every state of the union, it is felt that this area of activity can now be assumed at the state and local level.

c. Research Career Program: The purpose of this program has been to support the expansion of research programs concentrated on problems of mental health, and the establishment of new mental health programs by awards to appropriate institutions for the support of individual research scientists. NIMH has focused upon the development of research capacity in the psychiatric profession; engagement of investigators from a variety of the behavioral and biomedical sciences in mental health research; and the fostering of interdisciplinary research on mental health problems. Two types of awards available under this program include research scientist development awards (to develop research potential and provide independent research experience) and research scientist awards for the support of scientists qualified to conduct independent research and thus contribute significantly to the research programs of their sponsoring institutions. Estimates for 1974 and 1975 are set forth in the following table:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Research scientist development........	57	$1,710,000	32	$960,000	-25	-$750,000
Research scientist..	77	2,311,000	62	1,851,000	-20	-460,000
Research career.....	14	445,000	13	390,000	-1	-55,000
Total appropriation.	148	4,466,000	107	3,201,000	-46	-1,265,000
Obligations.........		(4,647,000)		(3,201,000)		(-1,446,000)

2. Intramural research: The NIMH intramural research program is devoted to investigating the causes, diagnosis, treatment, and prevention of mental disorders. It consists of three Divisions, two of them located on the campus of the National Institutes of Health, and a third at Saint Elizabeths Hospital. The program endeavors to study those problems in psychiatry, biology, chemistry and the behavioral sciences that are important for its mission, and that can be effectively attacked in its special facilities. Within these disciplines, the best criteria for choice of problems is long-term relevance to mental health. More specifically, the program includes clinical studies and basic research in a mix that varies from time to time, depending on the state of the art.

One important example of the intramural researcher's efforts would be the discovery of two enzyme abnormalities in the blood platelets of schizophrenic individuals. One of these is a deficiency in platelet monoamine oxidase, an important enzyme in the metabolism of biogenic monoamines. Researchers found that both schizophrenic and non-schizophrenic co-twins had the platelet abnormality. This indicated that the abnormality is genetically determined rather than being secondary to environmental factors which might accompany the schizophrenic process, such as the exposure to drugs, chronic hospitalization, and unusual diet. In addition, there was a high correlation between schizophrenic twins which also indicated that the enzyme abnormality was genetically controlled. The investigators believe that this is the first demonstration of an enzyme abnormality in schizophrenia which is genetic in origin; it represents an enzymatic marker for the vulnerability to schizophrenia.

The second abnormality studied was in an enzyme capable of forming the hallucinogen, dimethyltryptamine (DMT). This enzyme had previously been found to be elevated in schizophrenic and other psychotic individuals. Again the twin model was used for study. The DMT-forming enzyme activity was found to be elevated in the schizophrenic and not in the non-schizophrenic twin. It appears then, that this enzyme abnormality is environmentally rather than genetically controlled.

During the coming year, investigators will inquire into the nature of the genetic abnormality of platelet monoamine oxidase in schizophrenic patients. Such questions as the structure of the protein, how the enzyme abnormality is transmitted from one generation to another, and whether the abnormality is causative of the illness are under study.

In other areas, methods for more accurate and sensitive measurement of a variety of amine metabolites in brain, blood and cerebrospinal fluid are being developed. These are essential to further clinical studies on the rate of amine metabolism in brain.

Also continuing is a broad program of investigations of normal and pathological mechanisms underlying normal and abnormal growth, the development and maturation of the central nervous system, and a wide variety of studies to examine certain normally-occurring substances in brain. These will be related to drug effects, environmental and genetic factors, functional abnormalities and neuroendocrine regulation.

Data collection is now complete on a longitudinal study launched in 1966 aimed at understanding how preparental characteristics interact with congential characteristics of children in producing social, emotional, and cognitive development during the early years of life. Efforts will now be directed toward analyzing the data and reporting the results. Findings from preparatory studies in this project have already had considerable impact on the important field of family and child development and give some indication of the rich rewards which may be expected from the main longitudinal study. Throughout the past year the project leader has met with various committees of the Federal inter-agency panel on early childhood research and development. One result of these meetings is that other agencies have reported an interest in applying some of our findings to their intervention programs. An inter-agency panel has accepted our recommendation that an attempt be made to develop marker variables for use in future research in early development. These variables would make possible the more effective integration of findings from Federally-supported research, and progress toward establishing stable, consistent and verifiable findings would be accelerated. Members of the panel are concerned that some proposed changes in society, in education, in child rearing, and in family life, may be based on inadequate data.

A number of useful findings have emerged from studies of disturbed adolescents and their families. Of special interest is the mounting evidence that it is important to consider sickness not only in the individual himself but also in the context of the family in which the disturbance develops and the society in which it exists. In follow-up studies of such families, there is a correlation between improvement in the emotional life of the adolescent and in the marriage relationship of the parents. Other clinical studies of family interaction have revealed the important role of anxiety as a subjective experience which mobilizes and determines behavior within the family group. In these studies the usual behavioral observations were augmented by psychophysiological methods which substantially increased their validity.

The crucial developmental years in humans are the focus of a number of other intramural investigations. One such study attempts to ascertain how children acquire and modify their perspectives on illness and health; another deals with the important mental health variable of self-concept in children and how it develops; another with the development in young children of altruism and sensitivity to other people's feelings and needs; another deals with normal conduct and attempts to determine how various child rearing and training techniques would contribute to making an individual more consistently honest.

B. General Mental Health Training: The purpose of this activity is to increase the number and improve the quality of people working in the areas of mental health and mental illness by training personnel for clinical service and teaching; to develop and evaluate models of innovative training for new types of mental health personnel; and to provide continuing education for existing mental health manpower.

	1974 Base*	1975 Estimate	Increase or Decrease
Training grants and fellowships...........	$100,034,000	$65,101,000	-$34,933,000

In addition to regular training grants, this activity supports hospital staff development grants. The hospital staff development program is designed to increase the effectiveness of staff in mental hospitals, and to translate new knowledge into more effective service to patients. This activity also includes support for mental health fellowships. Training grants for drug abuse and alcoholism are excluded. Both are funded under separate activity headings.

Funding for the training program during the current and budget years is set forth below:

	1974 Base*	1975 Estimate
Training grants.................	$94,148,000	$59,501,000
Hospital Staff development......	2,400,000	1,600,000
Fellowships.....................	3,486,000	4,000,000
Total........................	100,034,000	65,101,000

1. Training Grants: Regular training grants are project grants authorized under Sections 301 and 303 of the Public Health Service Act. Funds are used to defray institutional costs of the training program (personnel, supplies, travel, equipment, etc.) and provide training stipends and other allowances for individuals enrolled in training programs. Tables #1 and #2 below show the distribution of training grant funds by type of grant and functional program respectively:

Table #1 - Distribution of Training Grants

	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations......	575	$32,671,000	1,045	$59,501,000	+470	+$26,830,000
Competing renewals.	1,088	55,065,000	---	---	-1,088	-55,065,000
New Projects.......	80	6,412,000	---	---	-80	-6,412,000
Supplemental awards	---	---	---	---	---	---
Total appropriation	1,743	94,148,000	1,045	59,501,000	-698	-34,647,000
Obligations........		(119,396,000)		(59,501,000)		(-59,895,000)

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* Excludes $27,987,000 in 1973 appropriation restorations.

Table #2 - Training Grants Program Distribution

	1974 Estimate	1975 Estimate	Increase or Decrease
Experimental and special	$13,209,000	$3,762,000	-$9,447,000
New careers	615,000	---	-615,000
Continuing education	2,220,000	---	-2,220,000
Psychiatry	31,267,000	21,131,000	-10,136,000
Epidemiology	331,000	239,000	-92,000
Psychiatric nursing	9,175,000	5,990,000	-3,185,000
Social work	12,609,000	9,285,000	-3,324,000
Behavioral sciences	24,722,000	19,094,000	-5,628,000
Total appropriations.	94,148,000	59,501,000	-34,647,000
Obligations	(119,396,000)	(59,501,000)	(-59,895,000)

Since its beginning in 1947 one of the cardinal missions of NIMH has been the development of well trained personnel to work in the mental health field. In the early years, the focus of support was primarily on the four core mental health professional disciplines: psychiatry, psychology, social work, and psychiatric nursing where there was a shortage not only of manpower but also of training institutions and departments capable of educating a large number of people in these fields. Through the mechanism of the training grant, institutions received funds, initially to help them grow and later to maintain the capability they had achieved.

While these efforts did result in increased numbers of personnel in the professional disciplines, it also became clear that the need for services was growing at an even faster rate, and that the supply of professionals could never be sufficient. Accordingly, programs were instituted to support the training of individuals to do research in the biological, clinical, and social aspects of mental illness, in order to arrive at a better understanding of its causes, and to provide more effective means of prevention, treatment, and care. Financial aid was also given to programs of continuing education for people working in the mental health field at all levels, and for the training of new types of mental health personnel - both professional and non-professional.

It is now felt that mental health training programs have been developed to the point that special Federal subsidies are no longer required - particularly in those professional fields for which there is a relatively high earning potential. Accordingly, beginning in FY 1975, all training grant activities of NIMH (including support both for student stipends and teaching costs) will be gradually phased out. No new awards are projected for any training grants during FY 1975.

During the current year, new awards will be made, both in the areas of categorical training and in the newer time-limited training programs of an experimental and developmental nature. The latter program makes it possible for the Institute to use a portion of its funds in an experimental manner, to see which new methods work and which do not, to evaluate programs closely, and to act as a clearinghouse for the dissemination of information on training, and to use this information in the Institute's role as technical advisor to State and local authorities.

2. Hospital Staff Development: The Hospital staff development grant program is designed to stimulate and assist state mental hospitals in initiating a sequence of change and improvements throughout the institutions.

The original goal was to strengthen and expand the training to provide opportunities for all levels of personnel to increase skills and knowledge in order to be more effective in meeting the needs of the patients by introducing active treatment methodologies.

A reduction of $800,000 is projected for this program in 1975, representing the initial step in the eventual phasing-out of Federal support in this area. In view of the many useful treatment models developed by this program, and in view of its wide geographic coverage, it is felt that the benefits of this program can be continued and expanded from state and local resources.

3. Fellowships: On July 9, 1973, a new NIH/NIMH manpower development program for post-doctoral research fellowships and institutional research fellowships was announced. This program will support researchers in priority research areas (i.e., those areas in which there is a demonstrated need for research manpower). A requirement of this program is that research fellows agree to a period of service in a research field subsequent to the completion of their training. During the current year approximately $3,256,000 will be invested in the new fellowships initiatives. A total of $1,261,000 would be available to fund new awards in 1975 under the new fellowship program.

The following table reflects the program levels projected for FY 1974 and FY 197

Distribution of Awards by Type

	1974		1975		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations.......	34	$230,000	442	$2,739,000	+408	+$2,509,000
New Projects........	141	3,256,000	105	1,261,000	-36	-1,995,000
Total appropriations	175	3,486,000	547	4,000,000	+372	+514,000
Obligations.......		(6,225,000)		(4,000,000)		(-2,225,000)

Distribution of Awards by Program

	1974		1975		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Predoctoral........	34	$230,000	442	$2,739,000	+408	+$2,509,000
Postdoctoral.......	76	2,475,000	80	880,000	+4	-1,595,000
Special............	65	781,000	25	381,000	-40	-400,000
Total appropriations	175	3,486,000	547	4,000,000	+372	+514,000
Obligations........		(6,225,000)		(4,000,000)		(-2.225,000)

A total of 400 new awards are expected to be made, under the old fellowships program, with $2,739,000 in released 1973 appropriations. Due to the lateness of the awards, no continuation requirements will be generated until FY 1975.

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C. General Mental Health Community Programs: Funds authorized under this activity are provided for the purpose of improving the organization, allocation and delivery of mental health servicess. The program levels for 1974 and 1975 are set forth in the following table:

	1974 Base*		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Community Mental Health Centers Program						
Construction...........	80	$14,250,000	--	---	-80	-$14,250,000
Staffing:						
Continuations........	456	125,250,000	513	$172,053,000	+57	+46,803,000
New projects.........	55	30,263,000	--	---	-55	-30,263,000
Subtotal...........	511	155,513,000	513	172,053,000	+2	+16,540,000
Child Mental Health:						
Continuations........	60	8,448,000	139	26,844,000	+79	+18,396,000
New projects.........	37	10,552,000	--	---	-37	-10,5[illegible]000
Subtotal...........	97	19,000,000	139	26,844,000	+42	+7,844,000
Total appropriations......	xx	188,763,000	xx	198,897,000	xx	+10,134,000
Obligations.............	xx	(208,763,000)	xx	(198,897,000)	xx	(-9,866,000)

Three major community programs are included under this activity, including construction and staffing of community mental health centers, and mental health services for children. It is proposed that the Community Mental Health Centers Act, the authority for all three of these programs, be allowed to expire on June 30, 1974. Accordingly no funds are being requested to initiate new projects. However, funds are being requested to continue Federal support for all projects currently receiving such support, so they will have the resources originally contemplated in making the grants. Accordingly, the FY 1975 budget request includes sufficient funds to meet continuation requirements for projects currently funded, in addition to those new staffing and child mental health projects which may be approved during the current year. It is felt that this program has proven itself, and should now be absorbed by the regular health service delivery system. Those programs which have operated efficiently will be able to obtain sufficient State, local and private moneys and third party reimbursements to continue to exist after their Federal support period has ended, as originally intended at the time of the legislation's initial enactment. In addition, the Administration's Comprehensive Health Insurance Plan (CHIP) is designed to cover virtually all acute mental health care and treatment on an equitable basis. Those communities which determine that a community mental health center is the ideal mental health delivery system for their needs can establish their own community mental health program or center, since most of the mental health centers will be covered by CHIP.

The phasing out of the community mental health centers program reflects the belief that the concept of community based care has been successfully demonstrated. Critical mental health services will be provided more equitably on a national basis by financing these services through increased reliance for funding from State, local and private sectors, and from health insurance.

During the current year, increased funding for the community mental health centers program enabled the National Institute of Mental Health to fund approximately 86 new centers, providing a total of 626 centers established through Federal financing.

1. Construction of Community Mental Health Centers: The purpose of the centers construction program has been to finance the building of public and other non-profit community mental health centers. Projects consisted of construction of completely new facilities or the acquisition, remodeling, alteration or expansion of existing facilities. The program was authorized under the Community Mental Health Centers (CMHC) Act of 1963, as amended, and as renewed in 1973.

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* Excludes $20,000,000 in FY 1973 appropriations.

2. Staffing of Community Mental Health Centers: Staffing grants have supported a portion of the initial salary costs for professional and technical staff in community mental health centers. Federal participation in staffing costs has enabled the community to initiate new or improved services and made them available while longer term sources of financial support were being developed. Under amended legislation, higher funding rates became available for centers serving designated poverty areas.

Funds requested in 1975 are limited to those which will be required to cover continuation costs generated by new awards made during the current year, plus those projects already approved. In view of the recent expansion in the number of Federally supported centers, the Administration believes that this activity has proven the value of community based delivery of mental health care and should now be absorbed by the regular health service delivery system, with greater reliance on operation funding from non-Federal sources including third party sources or state governments.

The number of funded and operational centers for June 30, 1973 and estimated for FY 1974 and 1975 is set forth in the following table:

	As of June 30		
	1973	1974	1975
Funded........................	540	626	626
Construction only..........	(108)	(154)	(154)
Construction & staffing....	(278)	(322)	(322)
Staffing only..............	(154)	(150)	(150)
Operational..................	391	45[illegible]	536

3. Mental Health of Children: This program was authorized under Part "F" of the Community Mental Health Centers Act, and provided Federal funds on a project grant basis for staffing grants to provide special services for children. Grants were awarded on a matching basis similar to the staffing program described earlier. These grants were awarded primarily to community mental health centers offering new or expanded services to children. A total appropriation of $19 million is provided in 1974. As is the case with staffing grants, the program is being phased out.

The 1975 request includes funds to support continuation costs of projects for which there is a current commitment. Included are continuation costs for 37 projects which received their initial awards from 1974 funds, and 42 new projects funded from released 1973 appropriations.

D. General Mental Health Management and Information: This activity supports the staff who are responsible for the planning, development and administration of the grant, contract, and direct operations programs relating to the area of general mental health. Funding levels proposed for 1974 and 1975 are set forth in the following table:

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits............	383	$12,060,000	373	$8,809,000	-10	-$3,251,000
Other Objects.........	---	11,103,000	---	7,944,000	---	-3,159,000
Total.................	383	23,163,000	373	16,753,000	-10	-6,410,000

The Management and Information activity includes the resources to support the provision of leadership, direction and policy in the development of NIMH goals, policies and programs. These resources also support the development of a data base upon which program activities can be monitored and evaluated. Staff supported under this activity collaborate with, provide assistance to, and encourage other local, state, national and foreign governments and organizations to promote mental health programs. This activity also supports the provision of information on mental health and illness to the public and to the scientific community. Grant and technical assistance programs are carried out by (1) the Division of Extramural Research Programs, which plans and administers research grant programs in the areas of behavioral sciences, clinical research, applied research, psychopharmacology, and epidemiologic studies; (2) the Division of Special Mental Health Programs, which administers programs directed toward problems of special significance such as crime and delinquency, metropolitan problems, mental health of children and families, and minority group mental health problems; (3) the Division of Manpower and Training Programs, which plans and administers programs of support for training of mental health personnel on a nationwide basis; (4) The Division of Mental Health Service Programs, which provides program planning at the national level for the Community Mental Health Centers Program.

The decrease for 1975 includes $3,678,000 for the annualization of the 1974 employment cutback, $100,000 associated with the reduction of ten positions in 1975, and a program reduction of $3,808,000 offset by built-in increases of $1,176,000.

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II. Drug Abuse

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation & benefits............	335	$8,371,000	406	$6,182,000	+71	-$2,189,000
Other expenses, obligations...........	---	264,043,000	---	210,433,000	---	-53,610,000
(Budget authority)....	---	(235,085,000)	---	(210,433,000)	---	(-24,652,000)
Total obligations.......	335	272,414,000	406	216,615,000	+71	-55,799,000
(Budget authority)....		(243,456,000)		(216,615,000)		(-26,841,000)

Narrative

The drug abuse programs of the Alcohol, Drug Abuse, and Mental Health Administration are carried out through the Agency's National Institute on Drug Abuse (NIDA) which is responsible for the formulation and implementation of a full range of drug abuse prevention activities. In carrying out these responsibilities, NIDA (1) conducts and supports research in various aspects of drug abuse - from investigating psychosocial and epidemiological factors influencing drug abuse - to studying the basic chemistry of abused substances; (2) supports training programs designed to provide sufficient number of qualified personnel in the field; and (3) assists communities, either through direct project grant support or through program consultation, in establishing treatment programs for drug abusers.

Heroin abuse emerged in the middle 1960's as a problem of major significance. Domestically, estimates of the extent of heroin abuse at one point reached beyond 500,000 addicts and users. This "epidemic" brought about the need for an immediate and massive mobilization of the nation's resources in order to address this problem. From FY 1970 through FY 1974, a total of $654,218,000 was obligated by the NIDA, including $460,566,000 for treatment and rehabilitation programs. By December 1973, there were 312 treatment programs funded with a total capacity for treating 95,000 patients at any one time. At the same time, State and local resources have been organized to supplement these initial efforts and to prepare to assume increasing responsibility for these functions.

In FY 1975 the Drug Institute will begin to shift away from the direct support of community treatment facilities and place greater emphasis on prevention activities. Operational responsibilities for treatment service programs will shift to State and local authorities. The Institute will also place a greater emphasis on program evaluation, particularly in the area of treatment effectiveness, and on the development of outreach programs for addicts who have not volunteered for treatment under existing programs.

	1974 Estimate	1975 Estimate
Research	34,056,000	34,[illegible]00,000
Training	15,138,000	[illegible],69,000
Community Programs:		
Project Grants & contracts	182,649,000	122,[illegible]00,000
Grants to states	25,000,000	35,[illegible]00,000
Management & information	15,571,000	15,[illegible]46,000
Total obligations	272,414,[illegible]00	216,[illegible]15,000

Authorization:
Research: Public Health Service Act, Sections 301, 3[illegible] and 3[illegible]
Training: Public Health Service Act, Sections 301, 3[illegible] [illegible]: DAOT Section 410
Community Programs:
Project Grants
. Public Health Service Act, Sections 301 and 30[illegible]
. Community Mental Health Centers Act, Section 2[illegible]1
. Drug Abuse Office and Treatment Act, Section 4[illegible]
Formula Grants: Drug Abuse Office and Treatment Act, Section [illegible]9
Management and Information: Public Health Service Act Sections 301, 302, and 303

Drug Abuse Research: New knowledge on the causes and effects of drug abuse is gained through support of basic, applied and clinical research activities. Funding levels are set forth below:

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research Grants Contracts	—	$26,[illegible]63,000	—	$30,[illegible]18,000	—	+$4,355,000
Intramural Research:						
Personnel compensation & benefits	108	5,[illegible]12,000	108	2,[illegible]07,000	—	-3,405,000
Other objects	—	2,181,000	—	1,[illegible]75,000	—	-1,006,000
Total	108	34,056,000	108	34,[illegible]00,000	—	-5[illegible],000

. Grants and Contracts: Research activities center on the development and clinical studies of new pharmacological therapies, including narcotic antagonists and long acting therapeutic drugs and integrating them into operational treatment programs; elucidation of socio-cultural family and personality variables related to addiction risk; testing the abuse potential of new drugs; understanding the mechanism of action of drugs of abuse and the addiction process; and continuing research into the long-term effects of marihuana use.

Research projects are authorized under the PHS Act and are awarded to public or non-profit agencies, research and academic institutions and other organizations. The following table shows the distribution of research grant and contract resources by type of grant:

	1974 Base		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
Continuations..........	68	$5,744,000	165	$14,099,000	+97	$8,355,000
Competing renewals.....	14	1,660,000	[illegible]	1,140,000	[illegible]	-520,000
New projects...........	103	8,902,000	63	5,422,000	-40	-3,480,000
Supplemental awards....	(5)	79,000	(5)	79,000	(---)	---
Subtotal, grants	185	16,385,000	[illegible]	20,740,000	[illegible]	+4,355,000
Contracts:...............	71	[illegible],878,000	71	9,878,000	---	---
Total Grants & Contracts	256	26,263,000	[illegible]	30,618,000	[illegible]	+4,355,000

Many aspects of narcotic addiction still hold questions for research. For example, basic research on the mechanisms of opiate action has made significant progress in identifying an opiate receptor site in the brain, i.e. the place in the brain where various narcotic drugs have their effect. While the full significance of this finding is not yet clear, it offers possibilities for the development of more effective, longer-lasting narcotic antagonists relatively free of side effects. Such substances, which block the action of opiates without being themselves addictive, may ultimately prove to be highly effective treatment and preventative tools. Major research programs are described as follows:

a. Marihuana: Basic research will be continued on the implications of the long term use of marihuana by American and overseas populations. Differing reports from various investigators regarding the possible relationships between marihuana use, chromosomal damage and birth anomalies will require further study and clarification. The effect of changing social and legal attitudes on patterns of marihuana and other drug use will be investigated along with the possible adverse consequences of the growing use of marihuana in combination with other licit and illicit drugs. The psychosocial characteristics of American users are also being explored.

b. Narcotic antagonists: Current efforts in this area range from the development of promising new compounds to the clinical testing of materials already demonstrating therapeutic potential. Intensive work is underway to develop a range of dosage forms and therapeutic vehicles which will extend the action of these drugs and make day-to-day therapeutic motivation of the addict less important.

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c. Analysis of Drugs of Abuse in Tissues and Body Fluids: The development of improved methodologies for detecting drugs of abuse in body fluids and tissues continues to be an important area of study. The development of automated methodology for routine analysis, as well as the development of highly sensitive quantitative methods for research use, will provide more reliable information on the extent and nature of drug abuse.

d. Research Drug Supply: Researchers are provided standardized natural and synthetic drugs of abuse which are unavailable commercially thereby accelerating research progress in marihuana and narcotic antagonists and shortening the time for developing new chemotherapeutic approaches to opiate addiction.

e. Stimulant Abuse: Increasing evidence of cocaine abuse has encouraged research on its mechanisms of action, metabolism, toxicity, neurophysiological and behavioral effects and, since it is often used simultaneously with other drugs, its interactive effects with such drugs.

f. Opiate Substitutes: The increased importance of methadone programs in heroin treatment requires research on a longer acting opiate substitute. Of critical importance is the investigation of possible treatment hazards associated with the increasing numbers of patients being treated in opiate substitute programs over long periods of time.

g. Basic Mechanisms of Drug Action: Research concerned with the basic mechanisms of action of the various drugs of abuse is essential to future innovative techniques. A better understanding of how drugs alter neurophysiological functioning and their basic mode of action makes possible improved methods of prevention, early intervention and treatment.

h. Poly-drug Abuse: Increasing evidence shows that abuse of single drugs or single classes of drugs is being supplanted by the abuse of multiple drugs. Use of various drugs in combination may produce more significant adverse consequences than might occur when each of the drugs is used separately. Research in this area will add to our understanding of the possible consequences of new and emerging patterns of poly-drug use.

i. Clinical Studies: Centers of research excellence are supported where the efforts of the basic and clinical researcher are integrated. In this way, the period required for the clinical application of basic research findings can be shortened. Research on the narcotic receptor in one of these eight centers already shows promise of improving present methods of prevention and therapeutic intervention.

Major research emphasis in FY 1975 will continue on (1) narcotic addiction and its treatment, with basic studies on the mechanisms of opiate action and identification of an opiate receptor in the brain. The development of more effective, longer-acting narcotic antagonists which are relatively free of side effects will be encouraged; (2) marihuana use, and a possible relationship between its use and chromosomal damage, mental impairment during periods of intoxication, birth defects, and deleterious effects on the body resulting from long-term use; (3) basic mechanisms of drug action, with study of the relationship of drug abuse as a behavior disorder with this type of compulsive and addictive disorders, including a wide variety of social and biological issues; (4) opiate substitutes, such as methadone, and the extent of treatment hazards associated with the increasing numbers of patients being treated in opiate substitute programs over long periods of time; (5) analysis of drugs of abuse in tissues and body fluids, in order to better detect this presence and develop improved methodologies for research use; and (6) research drug supply, providing researchers standardized natural and synthetic drugs of abuse which are unavailable commercially.

2. Direct Operations: Funds budgeted under this account in FY 1975 support the operation of the Addiction Research Center (ARC) in Lexington, Kentucky. Research activities at the Center are directed primarily at the nature of the addictive process and assessing the abuse potentiality of narcotic depressants, stimulants, and hallucinogens in an attempt to identify addicting drugs early and, through appropriate control, limit their abuse. ARC operations include research on methods of assessing in animals the abuse potentiality of depressants and hallucinogens; identification of narcotic antagonists that may have potential usefulness in the treatment of heroin addicts; validity of chemical methods for detecting drug use and dependence; and the social, cultural and environmental aspects of addiction.

B. Drug Abuse Training: The major purpose of the drug abuse training program is to ensure the availability of qualified manpower in the field. The major thrust of the Institute's activities will be the further development of a National Training System concept which includes the development of mechanisms for identifying training resources in the drug abuse field regardless of the funding source and research into existing and projected manpower needs. The major goal is to ensure greater utilization of existing training resources and a more effective approach to manpower needs as they develop. A total of 27,600 people received training in FY 1974.

	1974 Base		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
Continuations.........	71	$6,943,000	25	$2,495,000	-46	-$4,448,000
Competing renewals....	--	---	--	---	--	---
New projects..........	7	721,000	--	---	-7	-721,000
Supplemental awards...	--	---	--	---	--	---
Total grants.......	78	7,664,000	25	2,495,000	-53	-5,169,000
Contracts..............	8	7,474,000	8	7,474,000	--	---
Total training.....	86	15,138,000	33	9,969,000	-53	-5,169,000

1. Grants: Training grants are awarded under the authority of the Public Health Service Act (Sections 301, 302 & 303) to non-profit institutions for specialized training programs for the prevention and treatment of narcotic addiction and drug abuse. The training that medical students and students in health related areas receive on drug abuse is improved by increasing the number and knowledge of academic faculty and developing regular courses of instruction. Other programs support training of persons who come into direct contact with drug abusers, and provide in-service or short term instruction on treatment, rehabilitation, prevention, and evaluation of training methods. Training topics include pharmacology, urine surveillance, medical problems and patient care, treatment modalities and their management, and individual and group techniques

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for working with the addict. In 1975 support will be limited to continuation funding of a select number of training grant projects.

2 Contracts: Contract funds support the operation of the National Drug Abuse Training Center in Washington, D.C., and other training programs to meet the demands for health service delivery personnel. By the end of FY 1974, the contract centers will have trained individuals at all levels in job specific areas including program management, administration, clinical skills, and counseling.

a. The National Drug Abuse Training Center serves as a model for developing, validating, and testing training techniques and methodologies which have potential for application in community drug abuse treatment, rehabilitation, and prevention programs. The Center provides training to Federal, State, and local government officials, and other health professionals engaged in community programs to combat drug abuse. During 1974, approximately 1,[illegible]00 persons were trained.

b. Six regional training centers located in California, Florida, Oklahoma, Connecticut, New York, and Illinois provide short-term courses lasting from seven to fourteen days to meet the immediate demand for health service delivery personnel created by the growing number of federally and locally funded treatment programs. Instruction is provided on drug pharmacology, treatment and prevention, crisis intervention, maintenance therapy, counseling techniques, and psychological dependence. These courses are attended by professional and paraprofessional drug abuse and other health personnel who provide treatment services in community based treatment facilities. During 1974, approximately 4,000 people received training at these regional centers.

C. Drug Abuse Community Programs: Available data reveal that an alarming six year trend of increasing heroin addiction has been halted over the past two years. The rates of overdose death, serum hepatitis, and property crime -- regarded as significant indicators of the incidence of heroin addiction -- have declined through-out many areas of the country. At the same time, enrollment in NIDA funded treatment programs has nearly tripled from 20,576 in June 1972 to 55,629 as of December 1973.

With respect to the non-opiate drug category, the abuse of barbituates, amphetamines, hallucinogens, and cocaine are emerging as areas of equal concern. The extent of non-medical use of barbituates and amphetamines is difficult to estimate and the source of these drugs is not confined to illicit traffic. The social costs related to the abuse of these substances will be minimized by the Institute through continuing the availability of treatment, underwriting appropriate education efforts and informing the medical profession about the abuse potential when prescribing these substances.

With the sense of the immediate crisis past, the Federal role will shift in emphasis from the direct support of projects for drug abuse prevention to a more supportive role. In FY 1975 full attention will be given to preparing State and local agencies to become the primary focus of future prevention activities. The three major goals of the Institute will be: (1) to maintain the current level of Federally funded treatment capacity until the demand for treatment abates and/or the States can accept their full responsibilities; (2) develop national treatment standards for controlling both quality and efficiency of treatment; and, (3) to increase technical assistance to the States in preparing them to rapidly assume an increase in prevention responsibilities.

The FY 1975 budget request for community programs is adequate to continue support for existing treatment capacity. Expressed in terms of static capacity, i.e., the number of patients that can be treated at any one time, the Institute will be providing full or partial support for approximately 95,000 treatment slots. Although the length of a treatment program can vary considerably from individual to individual and program to program, it is estimated that over 161,000 patients will receive treatment in FY 1975. Based on the current demand for services this should be adequate to treat those addicts and drug abusers who volunteer for treatment as well as those new patients who will be enrolled as part of the Institute's planned outreach program which was initiated in FY 1974. Some shifting of funded treatment capacity among communities is planned so that resources which are not being adequately utilized in one area can be shifted to another area that has an unmet need.

	1974 Base	1975 Estimate	Increase or Decrease
Project grants & contracts..	$182,649,000	$122,000,000	-$60,649,000
Formula grants...............	25,000,000	35,000,000	+10,000,000
Total....................	207,649,000	157,000,000	-50,649,000
(Budget Authority)..	(175,770,000)		

1. Project Grants: Grants are awarded to assist communities to establish treatment programs for narcotic addicts and drug abusers under the provisions of the Community Mental Health Centers Act (CMHC) and the Drug Abuse Office and Treatment Act (DAOT). Project grant programs include: Staffing grants which provide for a portion of the salary costs of professional and technical personnel to staff comprehensive community centers for the treatment of narcotic addiction and drug abuse; projects which demonstrate new or relatively effective or efficient methods for delivering health services; service projects which provide Federal support for programs of treatment and rehabilitation which include detoxification services, institutional services, or community-based aftercare services; and, special project grants which provide support for treatment services, vocational rehabilitation, and evaluation projects.

Special emphasis will be given in FY 1975 to the support of demonstration projects designed to test innovative treatment techniques for potential replication at the State and local level. This is the most important element in the Institute's shifting its role from that of the direct funding of treatment projects to that of providing technical assistance, developing new knowledge and techniques, and supporting short-term treatment services where circumstances warrant brief direct Federal intervention. Of particular concern at the present time is the development of innovative approaches to treatment, the development of new methods for dealing with middle class populations of drug abusers, innovative ways to get drug abusers into the economic mainstream of life through employment programs, skills training and various types of rehabilitation, and the evaluation of existing procedures and techniques in the treatment of the drug abuser. Through the fostering of a viable demonstration program, the Institute can, on the Federal level, develop pragmatic knowledge in these areas and through its technical assistance capability work with the Single State Agencies and local programs to achieve beneficial impact at the level of direct service deliverer.

2. Contracts:

a. The Statewide Service Contract Program: This is a cost reimbursement, cost-sharing contractual mechanism under which many drug treatment and rehabilitation programs are supported under the "umbrella" of a single state drug abuse authority. The state drug authority assumes responsiblity as prime contractor for the various subcontractor agencies. This model is presently being developed in New Jersey, New York, and Texas for possible application in additional states. These projects are awarded under the authority of Section 410 of the DAOT Act. In 1975, these three projects will receive continuation funding of $10,800,000.

b. Expansion (Waiting List) Program: The financial burden facing existing agencies with insufficient treatment capacity for drug abusers already asking for care is relieved by provision of resources for the rapid expansion of treatment capacity on a fee-for-service contract basis. This program is also used to support new treatment facilities to meet existing needs in communities where there is not an established drug abuse treatment center. State drug abuse authorities are prime contractors for these awards. Two contracts totaling $1,000,000 will be funded in FY 1975.

c. NARA Program: The Narcotic Addict Rehabilitation Act (NARA) of 1966 provides an opportunity for individuals addicted to narcotic drugs to volunteer for civil commitment for treatment and allow addicted individuals charged with violating certain Federal criminal laws to apply for civil commitment in lieu of prosecution. $1.2 million in contracts will be funded in FY 1975.

3. Grants to States: These awards are made under the authority of Section 409 of the Drug Abuse Office and Treatment Act, and were first made available in FY 1973. Financial assistance is provided to the states for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions in the state and for evaluating the conduct of such functions. Funds are allocated to states based on a formula which measures the relative population, and financial and program need of each state. Federal funding through the formula grant mechanism will be increased from $25,000,000 in FY 1974 to $35,000,000 in FY 1975.

By 1975 it is anticipated that each state and territory will be operating under an approved plan and that a substantial portion of the funds will be used to provide drug abuse services, including planning, treatment, information development and reporting, and program administration. Formula grants will serve as the mechanism through which states will assume coordinating responsibility for drug abuse programs, including those which had previously been funded through individual categorical awards. The funding of drug abuse activities in this manner will provide a base suitable for incorporation into the ultimate third party system of funding adopted for drug abuse activities, such as national health insurance.

The following data reflect the actual and estimated awards for 1974/1975:

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	1974 Base		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
CMHC Act:						
Staffing - Sec. 251:						
Continuation...........	24	$13,405,000	24	$14,374,000	---	+969,000
Demonstration - Sec. 252:						
Continuation...........	7	3,026,000	---	---[2]	-7	-3,026,000
Service - Sec. 256:						
Continuation...........	101	66,945,000	---	---[2]	-101	-66,945,000
Education - Sec. 253:						
Continuation...........	13	1,700,000	---	---[2]	-13	-1,700,000
Total CMHC Act.......	145	85,076,000	24	14,374,000	-121	-70,702,000
DAOT Act:						
Special Project Grants & Contracts - Sec. 410:						
New.....................	76	19,707,000	9	4,540,000	-67	-15,167,000
Continuation...........	156	75,993,000	276	101,286,000	+120	+25,293,000
Subtotal.............	232	95,700,000	285	105,826,000	+53	+10,126,000
Formula Grants - Sec. 409:	56	25,000,000	56	35,000,000	---	+10,000,000
Total DAOT Act.......	288	120,700,000	341	140,826,000	+53	+20,126,000
NARA Act - Sec. 60[illegible]:						
NARA Contracts...........	38	1,500,000	30	1,200,000	-8	-300,000
PHS Act - Sec. 301/513:						
Evaluation...............	---	373,000	---	---	---	-373,000
Patient Care Contract....	---	---	1	600,000	+1	+600,000
Total PHS Act........	---	373,000	1	600,000	+1	+227,000
Total Obligations....	471	207,649,000[1]	396	157,000,000	-75	-50,649,000
Total Budget-Authority...		(175,770,000)				

D. Management and Information: This activity supports the staff of the National Institute on Drug Abuse responsible for planning, directing, coordinating, and implementing programs of research, training, community services, and public education for prevention and control of narcotic addiction and drug abuse. Included in this activity is the drug abuse information program which was established to collect and disseminate scientific, technical, and programmatic information on drug abuse from Federal and State drug abuse prevention efforts. Periodic and special reports and analyses will be provided for

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[1] Includes $31,879,000 funds carried forward from 1973 appropriation.

[2] Continuation funding provided under Section 410 of DAOT Act in FY 1975.

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operational and planning purposes by all federal agencies. A number of projects are being supported to develop an integrated management system.

Also included in this effort is the National Clearinghouse for Drug Abuse Information which distributes posters, pamphlets, publications, and other materials for use by the general public, researchers, teachers, physicians, interested groups and individuals.

During FY 1975 Special Action Office personnel will be absorbed into the organizational structure of the National Institute on Drug Abuse, reflecting conclusion of SAO's legislative mandate to develop and implement strategy to mobilize Federal efforts to combat drug abuse and addiction.

The additional personnel resources will aid the National Institute on Drug Abuse in responding to the increasing emphasis on non-opiate and poly-drug abuse. These resources will also assist new NIDA activities associated with its objective of allowing state and local agencies to become the primary focus of future treatment and rehabilitation activities.

The goal of the Clearinghouse in FY 1975 is to achieve fully operational drug abuse information system by July 1, 1975, which will 1) collect and maintain program management information emanating from Federal and state drug abuse prevention efforts;) provide periodic reports and analyses for use of all Federal, state and local agencies involved in the operation or planning of drug abuse activities; 3) provide consultation and liaison to decision makers requiring information on all areas of drug abuse, including treatment, rehabilitation, research training, and prevention.

Funding levels for FY 1974/1975 are set forth below:

	1974 Base		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..........	227	$2,759,000	298	$3,975,000	+71	+$1,216,000
Other objects..........	---	12,812,000	---	11,671,000	---	-1,141,000
Total..............	227	15,571,000	298	15,646,000	+71	+75,000

III. Alcoholism

	1974 Base*		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..	97	$2,779,000	113	$3,079,000	+16	$+300,000
Other expenses......................	---	135,130,000	---	96,787,000	--	-38,343,000
Total...............................	97	137,909,000	113	99,866,000	+16	-38,043,000

Narrative

This major grouping of activities encompases all programs of the National Institute on Alcohol Abuse and Alcoholism. The 1974 and 1975 funding levels for the Institute's major program areas are set forth in the following table:

	1974 Base*	1975 Estimate
Research......................	$8,489,000	$10,405,000
Training......................	6,824,000	1,947,000
Community Programs...........	112,556,000	77,651,000
Management and Information....	10,040,000	9,863,000
Total Obligations...........	$137,909,000	$99,866,000

Authorization:
Research: Public Health Service Act, Sections 301 and 303
Training: Public Health Service Act, Sections 301, 303, and 433
Community Programs:
Project Grants:
a. Public Health Service Act, Section 314e 1/
b. Community Mental Health Centers Act, Section 261
Formula Grants: Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Section 301 2/
Management and Information: Public Health Service Act, Sections 301 and 303

Since it was established by law in 1970, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has been the primary focal point for Federal activities in the area of alcoholism and, as such, has responsibility for formulating and recommending national policies and goals regarding the prevention, control, and treatment of alcohol abuse and alcoholism, and for developing and conducting programs and activities aimed at these goals. The most immediate goal of NIAAA is to assist in making the best alcoholism treatment and rehabilitation services available at the community level. The longer range goal is to develop effective methods of preventing alcoholism and problem drinking. To achieve these objectives, the NIAAA fosters, develops, conducts, and supports broad programs of research, training, development of community services, and public education.

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* Excludes $80,614,000 in 1973 appropriation restoration.

1/ Legislation proposed to incorporate alcohol project grants and contracts into Section 314e of the Public Health Service Act.

2/ Authorizing legislation expires June 30, 1974. An extension of the authorizing legislation is proposed.

A. Alcohol Research: The purpose of the Alcohol Research Program is to find better ways to treat, control, and prevent alcoholism and alcohol abuse; to plan and develop programs of basic and clinical research on the multiple causes of alcoholism, and on the treatment and rehabilitation of the alcoholic and alcohol abusers. Funding levels of FY 1974 and 1975 are set forth on the following table:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research grants and contracts	---	$8,023,000	---	$9,930,000	---	+$1,907,000
Intramural Research:						
Personnel compensation and benefits	6	285,000	6	294,000	---	+9,000
Other objects	---	181,000	---	181,000	---	---
Total	6	8,489,000	6	10,405,000	---	+1,916,000
(Obligations)		(13,189,000)		(10,405,000)		(-2,784,000)

. Grants and Contracts: Alcoholism research grants are made to investigators affiliated with hospitals, academic and research institutions, and other non-profit organizations. There are no matching requirements, but the grantee is required to share in a portion of the project cost. The following table shows the distribution of the research grants program by the type of grant:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations	64	$3,718,000	70	$4,306,000	+6	$+588,000
Competing renewals	5	962,000	3	769,000	-2	-193,000
New projects	37	3,286,000	120	3,098,000	+83	-188,000
Supplementals	(1)	57,000	(1)	57,000	---	---
Subtotal	106	8,023,000	193	8,230,000	+87	+207,000
Contracts	---	---	9	1,700,000	+9	+1,700,000
Total Grants and Contracts	106	8,023,000	202	9,930,000	+96	+1,907,000
(Obligations)		(12,723,000)		(9,930,000)		(-2,793,000)

The research grant program of the National Institute on Alcohol Abuse and Alcoholism has as its primary function the encouragement and support of scientifically important and methodologically sound research in the area of alcohol and its abuses. Since alcoholism is the result of a complex interaction of physiological, psychological, and sociological factors, research efforts deal with all levels of this major health problem, such as the etiology of alcoholism, basic and applied studies on the behavioral and biomedical effects of alcohol abuse, and research into the treatment, rehabilitation, and prevention of alcoholics and alcohol abusers.

Some specific areas of research supported by NIAAA in 1974 are: the etiology of liver cirrhosis and other alcohol-related diseases such as alcohol intoxication and pancreatitis; the study of the withdrawal syndrome and its treatment; identification of the mechanisms and enzymes responsible for the metabolism of alcohol; the development of an agent which could block the effect of alochol on the brain; the use of halfway houses for American Indians; identification and treatment of alcoholic women; the analysis of alcoholism treatment networks for enhancing the delivery of services to alcoholic patients; the investigation of a chemical substance having possible anti-alcohol effects; epidemiological studies of alcoholism; methods of early identification of alcoholics and research analyzing the economic costs of alcoholism. A total of 29 projects funded in FY 1974 will be funded for their entire project period.

During FY 1975, NIAAA will continue to support research activities currently underway. In addition, a number of new projects will be developed and supported in the areas of clinical research, prevention and education, behavioral and psychological studies, alcohol and driving, and the physiological effects of alcohol. Contracts will be awarded to study drinking practices and/or characteristics of alcohol abusers, the need for or availability of services for alcoholic persons, and the interaction between alcoholism and other diseases.

2. Intramural Research: In addition to grant support of research investigations, NIAAA operates a Laboratory of Alcohol Research at St. Elizabeths Hospital in Washington, D.C. In its efforts to clarify the nature of the addictive process in alcoholism and to measure its effects, the Intramural Research Program at the laboratory has developed three main thrusts: 1) studies of the behavioral aspects of alcoholism particularly as it relates to interaction within the family of an alcohol abuser and to the development of therapeutic procedures; 2) research into the mechanisms of importance in the metabolism of alcohol and on other bodily functions associated with alcohol ingestion abuse and withdrawal; and, 3) behavioral research on humans and experimental animals directed toward a clearer understanding of the effects of alcohol ingestion and the addictive process in alcoholism. In the Intramural Laboratory, experiments are designed so that findings in any single discipline would have a potentially meaningful relationship to research in other disciplines.

B. Alcohol Training - The purpose of the alcoholism manpower development activity is to improve the quality of training of professionals and paraprofessionals working in the areas of alcoholism and alcohol abuse. Training activities are supported for individuals in such fields as medicine, social work, public health, psychiatry, and psychology. Funding levels for 1974 and 1975 are shown in the following table:

	1974 Estimate	1975 Estimate	Increase or Decrease
Training grants........	$6,824,000	$1,947,000	$-4,877,000
(Obligations)..........	(12,224,000)	(1,947,000)	(-10,277,000)

It is the Institute's premise that the development of manpower should be for definite programs needing personnel with specific kinds of training, and, to this end, NIAAA has focused on three distinct groups of people and their roles in dealing with problems of alcohol abuse. The first group, counselors (usually individuals with less than professional training), provide most of the direct treatment services. The second group is composed of professionals who have acquired positive attitudes and recognize that alcoholic people can be helped. Independent of their disciplines, they are responsible for the supervision and training of personnel with less experience or training. The third group is composed of those members of a community who are in a natural position to provide entry into an alcoholism treatment system. This group includes clergy, physicians, attorneys, teachers, Indian medicine men, police; in short, any group to whom people in trouble turn for help.

During FY 1974, the thrust of the NIAAA manpower program will be directed toward the establishment of training centers in order to assure proximity and responsiveness to State and local training needs. These centers will be designed to accommodate alcoholism training needs of State and local organizations and will be coordinated with the NIAAA's National Center for Alcohol Education. In addition, new training grants will be awarded in several priority areas such as improving and developing curriculum on alcoholism in medical schools so that all students will be sensitized to the needs of alcoholic persons. The four new grants funded in FY 1974 will be funded for their entire project period.

The Institute's request for FY 1975 provides for continuation funding of existing training grants. Funding levels by type are set forth in the table that follows:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	Pos.	Amount
Continuation	36	$3,458,000	25	$1,947,000	-11	$-1,511,000
Competing renewals	10	229,000	---	---	-10	-229,000
New projects	4	3,137,000	---	---	-4	-3,137,000
Supplementals	---	---	---	---	---	---
Total	50	6,824,000	25	1,947,000	-25	-4,877,000
(Obligations)		(12,224,000)		(1,947,000)		(-10,277,000)

C. Alcohol Community Programs:

	1974 Estimate	1975 Estimate	Increase or Decrease
Project grants and contracts	$66,956,000	$32,051,000	$-34,905,000
Formula grants	45,600,000	45,600,000	---
Total	$112,556,000	$77,651,000	$-34,905,000
(Obligations)	(181,865,000)	(77,651,000)	(-104,214,000)

1. Projects Grants and Contracts: The objective of the alcoholism project grant and contract effort is to assist in reducing the seriousness, prevalence, and incidence of alcohol abuse through support of treatment, rehabilitation, and prevention at the local level. Support is available for a variety of purposes related to the improvement or expansion of alcoholism services: helping cover the initial salary costs of professional and technical personnel in facilities for the prevention and treatment of alcoholism; conducting surveys and field trials to evaluate the adequacy of prevention and treatment programs with a view toward determining ways of improving, extending and expanding such programs; demonstrating new, effective, or efficient methods of delivery of services to alcoholic persons; and, providing vocational, educational, or social services related to rehabilitation of alcohol abusers. High priority project grant programs include the following:

Indian Alcohol Program - The Indian Alcoholism Program has the following objectives: increase public understanding and awareness of the problem; change community attitudes toward this group; support rehabilitation sources; develop preventive programs for Indian youth; and design education and training programs in the field of Indian alcoholism. In FY 1973, the Institute funded 97 Indian projects designed to provide residential care, individual counseling, job placement, referral service, group therapy, Indian Alcohol Anonymous groups, didactic lectures, work therapy, recreation, and self-government. The essential aspect of these projects, however, is the integration of Indian cultural patterns into the rehabilitative and learning processes by hiring Indian staff for programs, working through individual tribal mores, and emphasizing the Indian's image of himself. It is intended that these demonstration projects, initially supported with Federal funds, would eventually continue without Federal support.

Alaskan Native Program - In addition to the regular Indian Program, NIAAA has initiated an Alaskan Native Program to develop alcohol treatment services for the people of Alaska. Forty-four "mini grants" of $5,000 - $10,000 each were awarded in FY 1973 to initiate education and organization efforts in various villages. The projects are largely one-year grants and the basic requirement is that the local community assume leadership in deciding on its needs and in doing the actual planning for these projects.

Drinking Drivers Program - The Drinking Driver Program is part of a joint effort with the Department of Transportation (DOT) whose objectives are the reduction of alcohol-related traffic fatalities and the encouragement of appropriate treatment for problem drinking drivers. NIAAA provides consultation and assistance in the development of the DOT community-oriented Alcohol Safety Action Program (ASAP), and support for treatment and rehabilitation of problem drinking drivers identified in ASAP operations. The Drinking Driver Program of NIAAA is concerned with utilizing the highway safety efforts of DOT to identify candidates for treatment early in the course of their problem with alcohol abuse and with changing the attitudes of police, judges, and probation officers toward acceptance of alcoholism as an illness and toward taking the responsibility for directing the drinking driver to treatment.

Occupational Program - NIAAA offers all States, Puerto Rico, the Virgin Islands, and the District of Columbia grants of $50,000 primarily to implement State-wide occupational programs. Staff support for two state employees is provided to develop a program for State employees and to develop similar programs in local jurisdictions and the private sector. The Institute has funded 51 such grants and has taken the initiative in training the State occupational staffs. This training is an ongoing 18-month program which provides over 100 occupational consultants throughout the country with a high level of expertise. The uniform training effort provided by the Institute fosters a close relationship with the State occupational staffs, and a coherent national effort in combatting alcoholism in the work force.

Poverty Program - In FY 1973, NIAAA funded 160 grants at $9,530,000 under the Community Alcoholism Services Poverty Program. The program's purpose is to demonstrate how a variety of services provided by different agencies can be coordinated and made available to the low income alcoholic person and his family. Some of the specific goals of these projects are: full utilization of community resources for early identification of low-income families with alcohol problems; improved access to and delivery of supportive services in the community needed

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for the recovery and the resocialization of these families, development and use of neighborhood resources for continued support of low income families with alcohol problems; maintenance of the family unit through socialization, rather than institutionalization of the alcoholic person; and, the development of training and technical assistance projects, using indigenous workers, to foster the spread of other programs in poverty areas.

During FY 1974, the project grant program of NIAAA will be focusing on several treatment initiatives: the development of standards for accreditation of alcoholism treatment programs and certification of treatment staff to bring about the active participation of the private health-care insurance industries and the recovery of benefits for the treatment of alcoholism; treatment programs keyed to specific sociocultural value expectations for such population groups as the employed, public inebriates, minorities, youth, and others; and, support for the implementation of the "Uniform Alcoholism and Intoxication Treatment Act" in the States, and consultation and assistance for those states already implementing such legislation. The Institute will be awarding funds to those new project grants which demonstrate innovative treatment techniques, a comprehensive approach to treatment, a willingness to meet accreditation standards, and a potential for excellence in these and other ways. Many of the projects funded in FY 1974 will be supported for their entire project period of up to three years.

The project grant program of NIAAA, since it was established in 1971, has funded over 480 projects in communities across the Nation. The effect of these projects has been to increase the national awareness of the problems of alcoholism and build State and local capacity to handle the problem. The final solution, however, must depend on locally initiated and supported efforts. Through the use of Federal assistance substantial results have been achieved, most notably in the sense that the programs funded have proven to be viable ones which merit support from the local and private sectors. During FY 1975, therefore, NIAAA proposes to phase-out direct Federal support for alcoholism service activities and concentrate its efforts on some new initiatives. These will include incentive contracts for $7,000,000 to profit-making institutions for organizing and establishing alcoholism treatment programs in private industry which can successfully solicit third-party payments for these treatment programs; $7,000,000 for project grants to States for implementation of the "Uniform Alcoholism and Intoxication Treatment Act"; and, $7,000,000 for new and continuation funding of selected high priority alcoholism treatment projects which are aimed at special risk populations. A distribution of alcoholism rehabilitation grants is set forth in the following table:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Staffing Grants:						
Continuations..............	45	$10,051,000	45	$11,051,000	---	$+1,000,000
Grants and Contracts:						
Continuations..............	386	41,671,000	94	6,000,000	-292	-35,671,000
New.......................	172	15,234,000	47	15,000,000	125	-234,000
Total....................	603	66,956,000	186	32,051,000	-417	-34,905,000
(Obligations)............		(106,265,000)		(32,051,000)		(-74,214,000)

2. Formula Grants: The State Formula Grant Program, provides funds to States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and

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rehabilitation programs to deal with alcohol abuse and alcoholism. Funds are allotted to the States according to a formula which is based upon relative population, financial need, and the need for more effective alcohol programs. All 50 States, the District of Columbia, Puerto Rico, the Trust Territories of the Pacific Islands, Guam, Samoa, and the Virgin Islands are participating in the formula grant program.

The State Formula Grant Program was first funded in FY 1972. The enthusiasm with which the program has been received, however, and the concerted efforts of the States to qualify for participation in the program are evidence of the positive impact it has and will have on the problems of alcohol abuse and alcoholism at the community level. The ways in which Formula Grant funds have been used by the States during the past year serves to illustrate this importance: 69.1% for direct services; 12.2% for Statewide program development; 8.4% for education, training, and prevention efforts; 3.9% for evaluation; and 6.4% for administrative costs.

D. Alcohol Management and Information: This activity supports the staff who plan, direct, and execute the programs of the National Institute on Alcohol Abuse and Alcoholism. Funding levels for FY 1974 and 1975 are set forth in the following table:

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	[illegible]	$2,494,000	107	$2,785,000	+16	$+291,000
Other objects	---	7,546,000	---	7,078,000	---	-468,000
Total	[illegible]	10,040,000	107	9,863,000	+16	-177,000

It is the established policy of NIAAA to include an evaluation component in all sponsored alcoholism programs and projects, and the scope of these monitoring and evaluation activities includes research, prevention, direct services, and training. The primary purpose of evaluation is to determine effectiveness and efficiency in the use of public funds in support of alcoholism programs, and to provide guidance in selection of appropriate alternatives. Results of evaluations are widely disseminated to all concerned in the field of alcoholism.

The information and education program of NIAAA has been expanding over the past several years. Initial efforts were devoted to building a foundation of awareness of the nature and scope of alcohol-related problems in the United States through a nationwide media campaign. This effort has been carried out through such means as public advertising; surveys of existing printed materials and films on alcohol; development of general and scientific publications; and production of films for junior high and high school youths. The Institute's information activities were consolidated when the National Clearinghouse for Alcohol Information (NCALI) was established in July 1972 to serve as the national focal point for the collection and dissemination of worldwide information on alcohol abuse and alcoholism. In addition to processing and responding to requests for information, the Clearinghouse provides abstracting, indexing, and cataloging services, and distributes bulletins and Clearinghouse publications.

The importance of prevention and education efforts has also been recognized by the Institute as deserving primary attention, and as a result, NIAAA has recently established the National Center for Alcohol Education (NCAE). Among the major goals of the National Center is the development of a comprehensive training and education system which, after testing and refinement, can be inexpensively adapted at the State and local levels. Of special importance is the capturing of the most innovative educational techniques and strategy coupled with thoroughly tested comprehensive curriculum materials. In addition, the Center will also provide Executive Seminars for State Alcoholism Authority directors as well as other policy makers from the local, State, and national levels.

During FY 1975, the Institute will continue those activities begun in prior years. The activities of both the Clearinghouse and the Education Center will continue to be closely evaluated, realigned, and refined in order to improve and enhance the Institute's efforts in making known and preventing the problems of alcohol abuse and alcoholism. The Institute will also maintain responsibility for administration of the PHS Federal Employee Alcoholism Program which it assumed in FY 1974.

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IV. Buildings and Facilities

	1974 Estimate	1975 Estimate	Increase or Decrease
Direct construction program.....	---	$200,000	+$200,000
Subactivities:			
Saint Elizabeths Hospital.....	---	---	---
Other..........................	---	200,000	+200,000
Total..........................	---	200,000	+200,000

Narrative

This represents a new budget activity under the Alcohol, Drug Abuse and Mental Health appropriation, through which we propose to fund all direct construction and facility improvement activities of the Alcohol, Drug Abuse and Mental Health Administration. Through the end of the current year, obligations of funds for these purposes will be reported under the former parent appropriation, Buildings and Facilities, Health Services and Mental Health Administration.

A. Saint Elizabeths Hospital: Major projects currently underway at Saint Elizabeths Hospital include the rewiring and extension of electrical facilties; plumbing and heating modernization and improvement; air conditioning of patient buildings; renovation of sanitary and storm sewers; and replacement of screens in hospital buildings. At the end of the current year, an estimated unobligated balance of $6,427,000 will be transferred from the Alcohol, Drug Abuse and Mental Health appropriation to that of the District of Columbia, as of June 30, 1974. Accordingly, no obligations are reflected under this appropriation for the Saint Elizabeths Hospital account, either in 1974 or 1975.

B. Other Programs: In 1975, the obligation of $200,000 reflects the planned construction of an animal fence and necessary landscaping at the NIMH research facility, located at Poolesville, Maryland. The funds were appropriated for this purpose under the HSMHA Buildings and Facilities account, in 1974.

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V. Program Direction

	1974 Estimate		1975 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits:						
Office of the Administrator....		$3,542,000		$3,191,000		-$ 351,000
Regional offices...		2,998,000		3,020,000		+22,000
Other expenses.........		2,606,000		4,251,000		+1,645,000
Total.............	290	$9,146,000	290	$10,462,000	--	+$1,316,000

Narrative

This activity, authorized by Section 301/303 of the Public Health Service Act, includes funds for the following purposes:

	1974	1975
A. Staff support for the Office of the Administrator, Alcohol, Drug Abuse, and Mental Health Administration..........	$5,062,000	$4,700,000
B. Staff support for Agency positions assigned to the DHEW Regional Offices.....	4,084,000	4,060,000
C. Rental costs for buildings occupied by Agency staff..............................	—	1,702,000
Total..............................	$9,146,000	$10,462,000

The Office of the Administrator, ADAMHA, includes the staff responsible for the overall direction and management of the Agency. The function carried out in the Administrator's office include administrative management services, program planning and evaluation, program coordination, and public affairs activities.

The staff assigned to the regional offices carry out programs of assistance to the states and serve as field units providing technical assistance on agency programs to state and community institutions. Regional offices have the responsibility for the administration, on a project basis, of the community mental health centers programs, the hospital improvement and hospital staff development programs, and the alcoholism formula grant program.

The Public Building Amendment of 1972 (P.L. 93-313) enacted by Congress, June 16, 1972, establishes an industrial funding method of operation for GSA from which the GSA operations, maintenance, and construction is to be funded. The law in effect requires each agency occupying space assigned by GSA to reimburse them for that space. This method of financing is applicable to all space administered by GSA regardless of whether it is federally owned or leased. This activity is utilized to reimburse GSA in accordance with that law, and contains an increase of $1,702,000 for this program.

Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Research (PHS Act, Sections 301 and 303).

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
330	$90,146,000 (101,427,000)	Indefinite (Obligations)	330	$84,468,000

Purpose: Provides funds to develop new knowledge and approaches to the causes, diagnosis, treatment, control and prevention of mental illness, through basic, applied and clinical research.

Explanation: Regular research grants go to investigators affiliated with hospitals, academic and research institutions, and other non-profit organizations. There are no matching requirements, but the grantee is required to share a portion of the costs. Hospital improvement grants are specifically focused on the use of current knowledge in demonstrating improved services for patients, stimulation of the process of change, and the development of relationships with community program for mental health.

Accomplishments in 1974: During the current year, a total of 1,048 projects will be funded, including 199 new awards, 1941 competing renewals and 150 small grants.

Objectives for 1975: The number and cost of awards by type are set forth in the following table:

Type	1974 Base		1975 Estimate	
	No.	Amount	No.	Amount
Research grants:				
Continuations....................	558	$36,337,000	645	$49,412,000
Competing renewals...............	141	8,123,000	107	5,650,000
New projects.....................	199	14,712,000	---	---
Small grants.....................	150	1,000,000	125	750,000
Supplementals....................	(39)	1,000,000	(39)	1,000,000
Subtotal.......................	1,048	61,172,000	877	56,812,000
Hospital Improvement Projects:				
Continuations....................	43	4,158,000	49	4,900,000
Competing renewals...............	9	857,000	---	---
New projects.....................	9	857,000	---	---
Subtotal.......................	61	5,900,000	49	4,900,000
Research Career Program:				
Continuations....................	130	3,934,000	107	3,201,000
Competing renewals...............	6	173,000	---	---
New projects.....................	12	359,000	---	---
Subtotal.......................	148	4,466,000	107	3,201,000

In the intramural research area, investigators will continue their studies into the genetic and chemical characteristics found in schizophrenic patients. In addition, there will be continuing study of the development and growth of the central nervous system, and wide variety of studies to examine various substances found in the brain. These will be related to drug effects, environmental and genetic factors, and functional abnormalities - all of which impact on the physical and chemical causes of various forms of mental illness.

Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Training grants and fellowships (Public Health Service Act, Sections 301, 303, and 433).

1974	Authorization	1975 Budget Estimate
$100,034,000 ($128,021,000 Obligations)	Indefinite	$65,101,000

Purpose: Training grants and fellowships support the effort to improve the quality of people working in mental health and to provide training for research relating to the problems of mental illness.

Explanation: Regular training grants are awarded to organizations to enable them to defray institutional costs of the training program and to provide stipends for individuals enrolled in these programs. Hospital staff development training grants are awarded to state mental hospitals to provide staff training aimed at increasing their overall effectiveness and translating new knowledge into more effective service to patients.

Accomplishments in 1974: In 1974, a total of 1,743 projects will be awarded, including 80 new starts. NIMH is also investing efforts in technical assistance to states and localities on the identification and means of meeting their manpower needs for mental health service personnel.

Objectives for 1975: The budget request for 1975 provides for continuation support to existing grantees. Funds are not being requested for new training grants since this program is proposed for phase-out. It is felt that mental health training programs have been developed to the point that special Federal subsidies are no longer required particularly in those professional fields for which there is a relatively high earning potential.

Funding and Project levels for 1974 and 1975 are set forth below:

Type	1974 Base No.	1974 Base Amount	1975 Estimate No.	1975 Estimate Amount
Training grants:				
Continuations	575	$32,671,000	1,045	$59,501,000
Competing renewals	1,088	55,065,000	---	---
New projects	80	6,412,000	---	---
Subtotal	1,743	94,148,000	1,045	59,501,000
Hospital staff development:				
Continuations	37	897,000	64	1,600,000
Competing renewals	51	1,303,000	---	---
New projects	8	200,000	---	---
Subtotal	96	2,400,000	64	1,600,000
Fellowships:				
Continuations	34	230,000	442	2,739,000
New projects	141	3,256,000	105	1,261,000
Subtotal	175	3,486,000	547	4,000,000
Total	2,014	100,034,000	1,656	65,101,000

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Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Construction (Community Mental Health Centers Act, as amended, Section 201).

1974	1975 Authorization	1975 Budget Estimate
$14,250,000 ($34,250,000 Obligations)	Expired	---

Purpose: Grants are made for the construction of public and other non-profit community mental health centers. Construction grants assist communities in establishing appropriate facilities for the delivery of comprehensive community mental health services by supplementing state, local and private financial resources.

Explanation: Funds appropriated for this program are allocated to the states on a formula basis, taking into account such factors as population and per capita income. Grants are awarded on a matching basis with the percent of Federal support varying depending upon whether or not the catchment area served has been designated as a "poverty area".

Accomplishments in 1974: Using $14,250,000 appropriated in 1974, plus $20 million carried forward from 1973, it is estimated that 194 new construction grants will be awarded (114 of which will be funded from 1973 funds).

Objectives for 1975: No new budget authority is requested for 1975. The Administration is proposing that the Community Mental Health Centers Act be allowed to expire at that time. Accordingly funds will no longer be requested to provide new starts for projects authorized under this Act. Reliance will be placed upon financing through state, local and private sources. On the basis of funding provided through the end of 1974, an estimated total of 576 centers will have received construction support by that time.

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Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Staffing (Community Mental Health Centers Act, as amended, Section 224).

1974	1975 Authorization	1975 Budget Estimate
$155,513,000	"Sums necessary for continuations"	$172,053,000

Purpose: Grants are made to assist in the establishment and operation of community mental health centers in areas designated by state mental health authorities as "catchment areas" (geographic areas containing between 75,000 and 200,000 people among which there is to be a coordinated, comprehensive system for providing mental health care). Grants are awarded on a project basis to eligible centers for partial support of staffing costs of professional and technical personnel.

Explanation: This assistance enables the community to initiate new or improved mental health services and make them available while longer term sources of financial support are being developed. Grants are award on a matching basis with the percent of Federal support varying, depending on whether the catchment area served has been designated as a "poverty" area.

Accomplishments in 1974: By the end of 1974, an estimated 55 new projects will be funded. of the anticipated 626 centers having received staffing and/or construction funding by the end of the fiscal year 1974, it is estimated that 455 will be fully operational, making services available to an estimated 67 million residents living in the catchment areas.

Objectives for 1975: During 1975 continuation funding will be provided for those projects underway or initiated through June 30, 1974. No new staffing awards will be made, as the Administration is proposing that the Community Mental Health Centers Act be allowed to expire on June 30, 1974. All commitments existing as of that time will be honored throughout their project periods. The proposal is consistent with Administration plans to place greater reliance upon health insurance, state and local revenues, income from the private sector, and third party payment systems, for financing treatment services.

It is felt that this program has proven itself, and should now be absorbed by the regular health service delivery system.

Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Children Services (Community Mental Health Centers Act, as amended, Part F).

1974	1975 Authorization	1975 Budget Estimate
$19,000,000	"sums necessary for continuations"	$26,844,000

Purpose: This activity supports grants which will improve the quality and quantity of services to children through specialized staffing grants.

Explanation: Funds are used to provide staffing support to existing community mental health centers or other qualified public or non-profit agencies and organizations, for the establishment or expansion of mental health services to children.

Accomplishments in 1974: By June 30, 1974 a total of 45 new projects have received awards from FY 1973 funds. An additional 37 new awards will be made from the 1974 appropriations.

Objectives for 1975: It is estimated that $26,844,000 will be required to support continuation commitments during 1975. It is proposed that the Community Mental Health Centers Act be allowed to expire on June 30, 1974. Accordingly funds will no longer be requested for new starts; however, all commitments for projects funded through the close of this fiscal year will be honored for their entire project periods.

It is felt that this program has proven itself, and should now be absorbed by the regular health service delivery system. Those programs which have operated efficiently will be able to obtain sufficient State, local and private moneys to continue to exist after their Federal support period has ended, as originally intended at the time of the legislation's initial enactment.

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Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Management and Information (Public Health Service Act, Sections 301 and 303).

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
383	$[illegible],163,000	Indefinite	373	$16,753,000

Purpose and Explanation: This activity supports the staff who are responsible for the planning, development and administration of the grants and contract programs included in the general mental health activities. Also included are the resources required for overall direction and management of the Institute, including program planning and evaluation, biometric and legislative services, administrative management, central office coordination of regional programs, and maintenance of Institute relationship with other branches of the Administration - and with state and community organizations.

Accomplishments in 1974: During the current year, a major effort has been invested in the reconstitution of NIMH as a component part of the Alcohol, Drug Abuse, and Mental Health Administration. In addition, an extensive analysis of NIMH programs is underway to determine those activities which may appropriately be decentralized to the regional level. Staffing reductions are underway, commensurate with the phasing-out of training and community mental health center programs.

Objectives in 1975: Consolidation of the recent reorganization into the Alcohol, Drug Abuse and Mental Health Administration; continuation of plans for decentralization.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Research (Public Health Service Act, Sections 301, 302, and 303)

1974		1975		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
108	$36,977,000 (34,056,000) Obligations	Indefinite	108	$34,000,000

Purpose: This subactivity supports drug abuse research grant and contract programs of NIDA and operation of the Addiction Research Center located in Lexington, Kentucky. Drug abuse research grants and contracts support the development of new knowledge and approaches to the causes, diagnosis, treatment, control and prevention of narcotic addiction and drug abuse through basic, clinical, and applied research.

Explanation: Project grants are available on a non-matching basis to public and private non-profit institutions. In addition, contracts are awarded on the basis of competition for research activities. Intramural research activities are supported at the Addiction Research Center, whose primary function is to test drugs for their abuse potential prior to their being made available for general use.

Accomplishments in 1974: During 1974 NIDA provided support for 256 research grants and contracts including 103 new awards. In addition to continuing existing efforts, the Drug Institute began clinical testing of longer acting narcotic antagonists, expanded research into psychological factors of drug abuse in minority and other high risk groups, increased research efforts on resource utilization and productivity in community service programs, and provided support for innovative treatment approaches. As a result of the expanding number of community based drug abuse treatment centers, the Institute was able to transfer the facility which housed the Lexington Clinical Research Center to the Bureau of Prisons in FY 1974. The operations of the Addiction Research Center are being continued.

Objectives for 1975: The FY 1975 request provides funding support for ongoing areas of major research to include (1) basic studies on the mechanisms of opiate action; (2) the development of more effective, longer-acting narcotic antagonists which are relatively free of side effects; (3) marihuana use, and a possible relationship between it use and chromosomal damage, mental impairment during periods of intoxication, birth defects, and deleterious effects on the body resulting from long-term use; (4) opiate substitutes, such as methadone, and the extent of treatment hazards associated with the increasing numbers of patients being treated in opiate substitute programs over long periods of time; and (5) analysis of drugs of abuse in tissues and body fluids, in order to better detect their presence and develop improved methodologies for research use. It is anticipated that 76 new research projects will be supported in FY 1975 at a level of $6,641,000 along with the continuation of 136 projects at a level of $23,977,000.

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ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Training (Public Health Service Act, Section 303; DAOT Section 410)

1974			1975 Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
---	$7,664,000	PHS-Indefinite	---	2,495,000
---	7,474,000	DAOT-160,000,000	---	7,474,000
---	15,138,000		---	9,969,000

Purpose: This activity supports training designed to increase the number and improve the quality and knowledge of people working in the area of narcotic addiction and drug abuse.

Explanation: Training grants are awarded to organizations to enable them to defray institutional costs of training programs, and to provide stipends to enrolled individuals. These are available to public or private non-profit institutions. Training contracts are awarded for regional training centers to provide short-term training for service delivery personnel.

Accomplishments in 1974: The major objectives in FY 1974 are to maintain the established level of training and at the same time achieve a fully coordinated, quality controlled, National Training System. Because of the urgent need for health service delivery personnel, the Institute has funded six contracts for regional training centers. During FY 1974, these centers provided short-term training for 4,000 workers at all levels, thus improving the quality and quantity of personnel working in Federal and locally funded rehabilitation centers. At the national level, the National Drug Abuse Training Center, which is operated under contract, provided training for 1,800 persons in FY 1974. The major objective of the drug abuse training grants program is to improve the quality of professional personnel available to work in the field of narcotic addiction and drug abuse. During FY 1974 NIMH funded 78 grants A total of 15,800 people were trained as a result of these grant programs.

Objectives for 1975: The 1975 request provides funds for grants having continuation requirements, but does not include funds for new grant awards. In addition, the request contains funding for the existing training center contracts. Efforts aimed at achieving a fully coordinated, quality controlled National Training System will be continued. It is estimated that 16,944 persons will receive training in FY 1975.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Community Programs - Project Grants and Contracts (Community Mental Health Centers Act, as amended, Section 256 and 261, and Drug Office and Treatment Act of 1972, Section 410, and Narcotic Addiction and Rehabilitation Act, Section 607).

1974		1975				
Pos.	Amount	Act.	Sect.	Amount	Pos.	Amount
--	$16,431,000	CMHC	261	"Sums as nec.	--	$14,374,000
--	19,883,000	CMHC	256	Expired 1/	--	---
--	1,700,000	CMHC	253	Expired 1/	--	---
--	91,256,000	DAOT	410	$160,000,000	--	105,826,000
--	1,500,000	NARA	607	"Sums as nec."	--	1,200,000
--	---	PHS	301/303	" " "		600,000
--	130,770,000					122,000,000
	(132,649,000) Obligations					

Purpose: This subactivity supports grants and contracts to develop and conduct comprehensive health and education programs for the prevention and treatment of drug abuse, thus reducing the problems associated with drug use and abuse in the United States.

Explanation: The project grants and contracts programs included in this activity are as follows:

1. Staffing grants support a portion of the initial salary costs for professional and technical staff to initiate comprehensive community centers while longer term sources of financial support are being developed.
2. Service projects provide partial Federal support for programs of treatment and rehabilitation which initiate detoxification services, institutional services, or community based aftercare services.
3. Project grants and contracts awarded under Section 410 of P.L. 92-255 authorizes a variety of programs to provide a full range of drug abuse prevention and treatment programs.
4. NARA contracts provide an opportunity for individuals addicted to narcotic drugs to volunteer for civil commitment for treatment (Title III) and allows addicted individuals charged with violating certain Federal criminal laws to apply for civil commitment in lieu of prosecution (Title I).

Accomplishments in 1974: A total of 471 awards were made. All new awards were made under the authority of Section 410 of the DAOT Act and were short term in nature - one to three years. The major objective in FY 1974 was to build federally funded treatment capacity to 95,000 treatment slots. Consistent with the increase in treatment capacity at the community level, Federal patient care provided under the Narcotic Addict Rehabilitation Act was reduced in FY 1974.

Objectives in 1975: Based on the current demand, further federal funding to expand treatment capacity is no longer necessary. Funds are provided to maintain existing federally funded treatment capacity. No new treatment awards will be made. Funds are also provided to support new demonstration models which demonstrate new and innovative treatment techniques. NARA contract funds are further reduced as a result of the increased number of community based facilities. In FY 1975 NIDA will fund 9 new project awards, 56 formula grant awards and 331 continuation project awards.

1/ Continuation funding provided under Section 410 of the Drug Abuse Office and Treatment Act.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Community Programs - Grants to States
(Drug Abuse Office and Treatment Act of 1972, Section 409)

1974			1975	
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
---	$15,000,000 (25,000,000) Obligations	Indefinite	---	$35,000,000

Purpose: These grants made under the authority of Section 409 of the DAOT Act provide financial assistance to States for planning, establishing, conducting and coordinating projects for the development of more effective drug abuse prevention functions in the State and for evaluating the conduct of such functions.

Explanation: Funds are allocated to States on the relative population, financial need, and the need for more effective conduct of drug abuse preventive functions. A portion of the allotment may be used to pay a portion of the costs of administering the state drug abuse prevention programs.

Accomplishments in 1974: The goal for 1974 was to have each State and territory operating under an approved State plan. A increased portion of the funds will be used by the States to provide drug abuse services.

Objectives for 1975: In FY 1975, formula grants will serve as the mechanism through which the State begins to assume an increasing responsibility for drug abuse programs including those which had previously been funded through individual categorical awards. They will be awarded to the States to cover multiple aspects of drug abuse, e.g. planning, treatment services, information development and reporting, and program administration.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity : Drug Abuse - Management and Information (Public Health Service Act, Sections 301, 302, and 303).

1974		1975		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
227	$15,[illegible]71,000	Indefinite	298	$15,646,000

Purpose: Funding is provided for the overall planning, direction and coordination of the Drug Institute's research, training, treatment and information program.

Explanation: This subactivity provides support for the National Institute on Drug Abuse, including personnel for planning, coordination, analysis, evaluation, and general administrative management. It supports the activities of the National Drug Abuse Information Programs which collects information on educational resources, government and private efforts, treatment facilities and populations served in the drug abuse area.

Accomplishments in FY 1974: In FY 1974 the Institute strengthened its administrative support capacity to assume effective integration and coordination of its total drug abuse effort. Also planned is an expansion of the information services with the goal of providing a resource for policy and strategy studies, as well as serving as a source of information for performance evaluation.

Objectives for 1975: Efforts will continue toward achieving a totally integrated drug abuse information program. This system when fully operational will collect and maintain program and management information emanating from Federal and state drug abuse prevention efforts and provide periodic and special reports and analyses for operational planning purposes of all Federal agencies. In addition, basic informational tools will be provided to management at the local, state, and Federal levels necessary to ensure that drug abuse prevention resources are being programmed, allocated, and maintained in an effective, efficient, legal, and accountable manner. Personnel engaged in general program direction and those engaged in treatment program management will concentrate more heavily on shifting from an orientation of crisis intervention through direct Federal grants for treatment to one which provides technical assistance to regional offices and States in the administration of comprehensive prevetion programs through formala grants and/or revenue sharing to States. Major efforts will be made to refine and further evaluate files to achieve a fully operational training, education, treatment, evaluation, and information in both the Federal and private sector. Also, greater emphasis will be placed on program evaluation, particularly in the area of treatment effectiveness and on the development of outreach programs for addicts who have not volunteered for treatment under existing programs.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Research (Public Health Service Act, Section 301 (c) and 303).

1974			1975 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
6	$8,489,000	Indefinite	6	$10,405,000
	13,189,000 Obligations			

Purpose: This activity includes funds for intramural and extramural research programs to find better ways to treat, control and prevent alcoholism and alcohol abuse; to plan and develop programs of basic and clinical research on the multiple causes of alcoholism; and to stimulate, support and conduct biological, pharmacological, behavioral and sociological research in alcoholism.

Explanation: Project grants are available on a non-matching basis for expenses directly related to the research project; however, the grantee is required to share a portion of the project cost. An intramural research program is also supported to clarify the nature of the addictive process and to analyze the biological, behavioral, and biochemical correlates of alcoholism in man and animal.

Accomplishments in 1974: In FY 1974, a total of 106 awards were made including 37 new projects. Priority was given to projects focusing on prevention and treatment techniques including studies on the epidemiology of alcoholism, projects identifying new and promising psychological techniques, and research into the early identification of alcohol problems.

Objectives in 1975: During 1975, the Institute will continue to support projects having continuation funding commitments. New projects will be developed and supported in the areas of clinical research, prevention and education, behavioral and psychological studies, alcohol and driving, and the physiological effects of alcohol. A total of 202 awards will be made including 129 new awards.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Training (Public Health Service Act, Section 303)

1974		197		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$6,824,000 (12,224,000) Obligations	Indefinite	---	$1,947,000

Purpose: This activity provides funds to improve the quality of people working in areas of alcoholism and alcohol abuse by training personnel for clinical services, teaching and research; to provide technical training for ancillary personnel, and continuing education for existing manpower in the fields of alcoholism and alcohol abuse.

Explanation: Project grants are awarded on a non-matching basis, but the grantee is required to share a portion of the project costs.

Accomplishments in 1974: In 1974, a total of 50 awards were made, including 4 new projects. High priority was given to the establishment of training centers to assure proximity and responsiveness to State and local training needs. Other high priority programs include providing curriculum in medical schools; projects integrating a variety of community training resources, and developing training models and demonstrations with built-in evaluations and community resource utilization systems.

Objectives for 1975 The Institute will provide continuation funding to the extent necessary to honor prior commitments. It is anticipated that 25 continuation grants may be awarded.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Community Programs - Project Grants and Contracts; PHS Act, Sec. 314e, and Community Mental Health Centers Act, Sec. 261.

1974			1975	
				Budget Estimate
Pos.	Amount	Authorization	Pos.	Amount
---	$10,0[illegible]1,000	CMHC Act "Sums as necessary"	---	$11,051,000
---	56,9[illegible],000	1/	---	21,000,000
---	$66,9[illegible],000			$32,051,000
	(106,2[illegible],000) Obligations			

Purpose: Alcoholism project grants are made to reduce the seriousness, prevalence and incidence of alcoholism through support of community treatment, rehabilitation and prevention programs, and promotion of programs which demonstrate new or relatively efficient methods of service delivery to alcoholics.

Explanation: Project Grants and Contracts supported by this activity are as follows: Staffing grants are made on a matching basis and support a portion of the material costs of professional and technical staff in facilities for the prevention and treatment of alcoholics. Federal participation in staffing costs enables the community to initiate new or improved services and makes them available while longer term sources of financial support are being developed.

Grants and contracts are awarded for a variety of programs including demonstration treatment models, planning grants to States, and projects targeted at reducing and preventing alcoholics in special populations. Matching funds are normally not required in these programs.

Accomplishments in 1974: In 1974, a total of 805 awards including 404 new awards were made. High priority programs included programs targeted toward special high risk populations such as Indians, Alaskans, and the poor; projects demonstrating programs to reduce the number of drinking drivers and also encourage treatment for drinking drivers; programs treating the drinking worker in the occupational setting; and new projects which demonstrate innovative techniques with applicants who show a willingness to meet accreditation standards.

Objectives for 1975: The Federal assistance concept has been demonstrated and substantial results have been achieved. Therefore, during FY 1975, NIAAA proposes to phase out alcoholism service projects as a Federally supported program, and concentrate its efforts on some new iniatives. These include incentive contracts to profit-making institutions to organize alcoholism treatment programs in private industry; planning grants to States to implement the "Uniform Alcoholism and Intoxication Treatment Act"; and for continuation funding of selected high priority treatment projects which are aimed at special risk populations. A total of 186 of these awards will be made. In addition, continuation awards will be made to honor existing commitments to 45 staffing grants.

1/ Legislation proposed to incorporate alcohol project grants and contracts into Section 314e of the Public Health Service Act.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcohol - Community Programs - Grants to States (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Section 301)

1974		1975		
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
---	$45,600,000 (75,600,000) (Obligations)	1/	---	$45,600,000

Purpose: Section 301 of the Comprehensive Alcohol Abuse and Alcoholism Act of 1970 (Public Law 91-616) authorizes formula grants to States for the planning, establishment, maintenance, coordination and evaluation of projects for the development of alcoholism prevention, treatment and rehabilitation programs.

Explanation: Funds are allotted to States on the basis of their relative population, financial need and the need for a more effective prevention treatment, and rehabilitation program. At the request of any state a portion of any allotment shall be available to pay some of the cost of the administration of the state alcoholism programs. Plans submitted by the states must set forth a survey of need for the prevention and treatment of alcohol abuse and alcoholism, including an assessment of the health facilities needed to provide services.

Accomplishments in 1974: In 1974, 69% of the funds allotted to the states were utilized for direct services. The remaining funds were used as follows: Statewide program development 12%; education, training and prevention 8%; evaluation 4%; and administrative costs 7%.

Objectives for 1975: In 1975, a plan of utilization similar to that in FY 1974 is anticipated.

1/ Legislation authorizing this program expires June 30, 1974. Additional authorizing legislation will be submitted.

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ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health
Program Purposes and Accomplishments

Activity: Alcohol - Management and Information (Public Health Service Act, Section 301/303)

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
91	$10,040,000 (11,245,000) Obligation	Indefinite	107	$9,863,000

Purpose: To provide overall planning, direction and coordination of the alcoholism prevention, treatment, training and research programs; to provide information services for the alcoholism program and administrative support for the various components of the National Institute on Alcohol Abuse and Alcoholism.

Explanation: This subactivity provides staff support for the National Institute on Alcohol Abuse and Alcoholism which carries out the following functions: 1) Planning, direction and evaluation of alcoholism programs at NIAAA; 2) Development of policy guidance and staff direction in such areas as program coordination and review, research, administrative management, and manpower and resource development; 3) Serves as a focal point for the national alcohol abuse and alcoholism effort; 4) Provision of professional and technical assistance to the DHEW Regional Offices, State and local governments, and private organizations, and; 5) Coordination of the Institute's interagency and intergovernmental alcoholism programs.

This subactivity also provides support to the Institute's National Clearinghouse on Alcohol Information. The missions of the Clearinghouse are to develop public recognition of alcoholism as an illness for which the afflicted individual needs help; to encourage the health system to accept alcoholism as a medical and social behavioral problem, and to treat the alcoholic as one would any other person with an illness; to develop public awareness of the properties and effects of alcohol; and to encourage a public attitude which will be more conducive to the responsible use of alcohol. Finally, this subactivity provides support for the National Center for Alcohol Education.

Accomplishments in 1974: The Institute's information and education programs received high priority in FY 1974. Initial efforts were devoted to building a foundation of awareness of the nature and scope of alcohol-related problems in the United States. This has been carried out through such means as public service advertising, surveys of existing printed materials and films on alcohol, development of general and scientific publications, and production of a film for junior high and high-school use. In addition, the National Center for Alcohol Education provided a model for initiatives and innovations in alcoholism education.

Objectives for 1975: In 1975, technical assistance will continue to be provided to States and local governments in development of non-Federal funding sources for alcoholism services, in program development and encouragement of State, local, public and private groups in expanding their efforts in prevention, education, and treatment, and in development of innovative programs directed toward the solution of alcohol abuse and alcoholism problems among special target groups. The national focal points for alcohol information and education found in the National Clearinghouse for Alcohol Information and the National Center for Alcohol Education, respectively, will continue to be developed and expanded. Every effort will be made to ensure that information gained through the expanded research activity will be communicated to the field and applied to treatment and prevention programs supported by Federal, State, and local monies.

Alcohol, Drug Abuse and Mental Health Administration

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: Buildings and Facilities

1974			1975		
				Budget Estimate	
Pos.	Amount		Authorization	Pos.	Amount
---	---	Obligations	Indefinite	---	$200,000
---	---	Budget Authority		---	---

Purpose: For construction, alterations and repairs and improvements of buildings and facilities of the Alcohol, Drug Abuse and Mental Health Administration, including preparation of plans and specifications.

Explanation: This represents a new budget activity under the Alcohol, Drug Abuse and Mental Health appropriation. Appropriated funds will remain available until expended.

Accomplishments in 1974: Current year obligations will be reported under the former parent appropriations, Buildings and Facilities, Health Service and Mental Health Administration. Balances applicable to ADAMHA programs will be transferred to this account as of the close of the current fiscal year. At that time, there will also be a simultaneous transfer, from this appropriation to that of the District of Columbia, of those balances allocable to Saint Elizabeths Hospital. The latter transaction relates to the proposed transfer of the Hospital to District of Columbia control in 1975.

Objectives in 1975: Obligation of $200,000 in 1975 reflects the planned construction of an animal fence and necessary landscaping at the NIMH research facility, located at Poolesville, Maryland.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse and Mental Health

Program Purpose and Accomplishments

Activity: Program Direction (Public Health Service Act, Section 303)

1974			1975	
			Budget Estimates	
Pos.	Amount	Authorization	Pos.	Amount
290	$9,146,000	Indefinite	290	$10,462,000

Purpose: These funds support staff involved in the overall direction and management of the Agency.

Explanation: The functions carried out in this activity include program planning and evaluation, program coordination, administrative management services, and public affairs activities. Also included are operating costs of general mental health, alcoholism, and drug abuse personnel located in the DHEW Regional Offices. In addition, the Public Building Amendment of 1972 (P.L. 92-313) enacted by Congress, June 16, 1972, established an industrial funding method of operations for GSA from which the GSA operations, maintenance and construction is to be funded. The law, in effect requires each agency occupying space assigned by GSA to reimburse the GSA for that space. This method of financing is applicable to all space administered by GSA regardless of whether it is federally owned or leased. This activity is utilized to reimburse GSA in accordance with that law, and contains a program increase of $1,[illegible]02,000 for this program.

Accomplishments in 1974: Particular emphasis in FY 1974 was given to evaluation of the Agency's information activities and reorganizing NIMH into the Alcohol, Drug Abuse, and Mental Health Administration.

Objectives for 1975: The Agency will continue its efforts to evaluate the effectiveness of its programs, and work to improve coordination and collaboration between headquarters, the regional offices, and state and local mental health agencies. Efforts will continue to effectively administer and achieve the proper coordination of programs among the three Institutes. In addition, the Agency will evaluate programs to determine which additional ones should be administered in the DHEW regional offices.

Allocation of Funds for Drug Abuse

Formula Grants

	1974 Allocations	1975 Allocations
Alabama..................	$483,916	$690,702
Alaska...................	100,000	100,000
Arizona..................	241,069	344,083
Arkansas.................	282,984	403,908
California...............	2,149,422	3,067,911
Colorado.................	273,661	390,602
Connecticut..............	306,083	436,878
Delaware.................	100,000	100,000
District of Columbia.....	211,453	211,453
Florida..................	887,167	1,266,270
Georgia..................	596,588	851,522
Hawaii...................	100,000	122,569
Idaho....................	104,619	139,627
Illinois.................	1,217,821	1,649,820
Indiana..................	611,290	872,506
Iowa.....................	338,627	483,328
Kansas...................	258,984	369,653
Kentucky.................	438,812	626,325
Louisiana................	499,445	712,867
Maine....................	132,851	189,6[illegible]1
Maryland.................	433,141	618,231
Massachusetts............	617,521	881,400
Michigan.................	970,728	1,385,539
Minnesota................	447,624	638,902
Mississippi..............	336,923	480,896
Missouri.................	549,514	784,331
Montana..................	100,000	126,078
Nebraska.................	177,662	253,580
Nevada...................	100,000	100,000
New Hampshire............	100,000	131,463
New Jersey...............	874,347	1,064,698
New Mexico...............	145,922	208,277
New York.................	1,840,077	2,626,377
North Carolina...........	672,239	959,500
North Dakota.............	100,000	117,323

Allocation of Funds for Drug Abuse

Formula Grants

	1974 Allocations	1975 Allocations
Ohio......................	1,196,049	1,707,144
Oklahoma..................	335,073	478,256
Oregon....................	259,008	369,688
Pennsylvania..............	1,337,492	1,909,028
Rhode Island..............	109,192	155,852
South Carolina............	369,223	526,999
South Dakota..............	100,000	127,502
Tennessee.................	539,485	770,018
Texas.....................	1,426,749	2,036,427
Utah......................	154,158	211,167
Vermont...................	100,000	100,000
Virginia..................	561,952	802,084
Washington................	383,608	547 531
West Virginia.............	237,394	338,837
Wisconsin.................	529,360	755,565
Wyoming...................	100,000	100,000
Guam......................	13,679	19,525
Puerto Rico...............	417,855	596,413
Virgin Islands............	10,759	15,356
American Samoa............	4,381	6,253
Trust Territory...........	14,093	20,115
Total.....................	25,000,000	35,000,000

Allocation of Funds for Alcohol

Formula Grants

	1974 Allocations	1975 Allocations
Alabama..................	$906,851	$890,059
Alaska...................	200,000	200,000
Arizona..................	411,656	443,396
Arkansas.................	508,619	520,488
California...............	3,925,628	3,953,404
Colorada.................	487,723	503,342
Connecticut..............	568,264	562,975
Delaware.................	200,000	200,000
District of Columbia.....	200,000	200,000
Florida..................	1,548,183	1,631,753
Georgia..................	1,087,308	1,097,297
Hawaii...................	200,000	200,000
Idaho....................	200,000	200,000
Illinois.................	2,149,246	2,126,007
Indiana..................	1,124,581	1,124,337
Iowa.....................	620,481	622,831
Kansas...................	474,299	476,346
Kentucky.................	812,886	807,102
Louisiana................	918,753	918,622
Maine..	241,624	244,351
Maryland.................	794,988	796,670
Massachusetts............	1,135,051	1,135,798
Michigan.................	1,804,708	1,785,446
Minnesota................	827,786	823,308
Mississippi..............	626,433	619,697
Missouri.................	1,036,612	1,010,713
Montana..................	200,000	200,000
Nebraska.................	325,163	326,771
Nevada...................	200,000	200,000
New Hampshire............	200,000	200,000
New Jersey...............	1,391,575	1,372,001
New Mexico...............	255,048	268,392
New York.................	3,425,960	3,384,428
North Carolina...........	1,240,918	1,236,440
North Dakota.............	200,000	200,000

Allocation of Funds for Alcohol

Formula Grants

	1974 Allocations	1975 Allocations
Ohio	2,240,257	2,199,876
Oklahoma	616,007	616,295
Oregon	466,827	476,391
Pennsylvania	2,493,783	2,460,031
Rhode Island	202,830	200,835
South Carolina	677,129	679,106
South Dakota	200,000	200,000
Tennessee	988,869	992,268
Texas	2,580,320	2,624,200
Utah	263,997	272,108
Vermont	200,000	200,000
Virginia	1,042,563	1,033,590
Washington	714,446	705,565
West Virginia	441,501	436,635
Wisconsin	978,442	973,644
Wyoming	200,000	200,000
Guam	23,849	25,160
Puerto Rico	766,619	768,555
Virgin Islands	16,421	19,788
American Samoa	7,472	8,058
Trust Territory	28,324	25,921
Total	45,600,000	45,600,000

NEW POSITIONS REQUESTED

	1975		
DRUG ABUSE	GRADE	NO.	ANNUAL SALARY
Chief, Division of Community Assistance	GS-15	1	$28,263
Project Manager	GS-15	2	56,526
Medical Officer	GS-15	1	28,263
Project Manager	GS-14	1	24,247
Systems Analyst	GS-14	1	24,247
Regional Coordinator	GS-14	1	24,247
Training Specialist	GS-14	1	24,247
Program Evaluation Officer	GS-14	1	24,247
Program Analyst	GS-14	2	48,494
Social Science Analyst	GS-13	1	20,677
Training Specialist	GS-13	1	20,677
Public Health Analyst	GS-13	2	41,354
Statistician	GS-13	1	20,677
Contract Specialist	GS-13	1	20,677
Program Specialist	GS-13	1	20,677
Assistant Project Manager	GS-13	1	20,677
Project Development Specialist	GS-13	1	20,677
Auditor	GS-13	2	41,354
Statistician	GS-12	1	17,497
Training Specialist	GS-12	1	17,497
Public Health Advisor	GS-12	1	17,497
Legal Assistant	GS-12	1	17,497
Program Specialist	GS-12	1	17,497
Administrative Assistant	GS-12	1	17,497
Statistician	GS-12	1	17,497
Program Analyst	GS-11	2	29,342
Social Science Analyst	GS-11	2	29,342
Public Health Advisor	GS-11	1	14,671
Research Assistant	GS-11	1	14,671
Program Specialist	GS-11	1	14,671
Staff Assistant	GS-9	1	12,167
Public Health Advisor	GS-9	2	24,334
Auditor	GS-9	1	12,167
Administrative Assistant	GS-9	1	12,167
Procurement Assistant	GS-9	1	12,167
Secretary/Stenographer	GS-8	2	22,058
Program Analyst	GS-7	1	9,969
Statistical Assistant	GS-7	1	9,969
Secretary/Stenographer	GS-7	2	19,938
Education and Training Assistant	GS-7	1	9,969
Library Technician	GS-6	1	8,977
Audit Clerk	GS-6	1	8,977
Computer Operator	GS-6	1	8,977
Fiscal Clerk	GS-6	1	8,977
Secretary/Stenographer	GS-6	1	8,977
Biolaboratory Technician	GS-5	1	8,055

Secretary	GS-5	3	$24,165
Clerk/Typist	GS-4	8	57,584
Clerk/Typist	GS-3	2	12,816
Supply Clerk	GS-3	1	6,408
Messenger	GS-2	1	5,682
Clerk	GS-2	1	5,682
		71	$1,045,586

ALCOHOL

Health Services Administrator	GS-15	1	28,263
Medical Officer	GS-15	1	28,263
Medical Officer	GS-14	1	24,247
Public Health Advisor	GS-13	1	20,677
Research Psychologist	GS-13	1	20,677
Education Specialist	GS-12	2	34,994
Social Science Analyst	GS-12	3	52,491
Alcoholism Counselor	GS-12	1	17,497
Secretary	GS-5	2	16,110
Clerk/Typist	GS-4	2	14,396
Clerk/Typist	GS-3	1	6,408
		16	264,023
Total new positions, all activities		87	$1,309,609

Wednesday, April 3, 1974.

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

WITNESSES

DONALD C. PARKS, ACTING ASSOCIATE ADMINISTRATOR FOR MANAGEMENT

JOHN P. BUCKLEY, ACTING DIRECTOR, DIVISION OF FINANCIAL MANAGEMENT

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Mr. Flood. Now we have the Health Resources Administration, Payment of Sales Insufficiencies and Interest Losses. The presentation will be made by Donald C. Parks, Acting Associate Administrator for Management.

We will put your statement in the record.

[The statement follows:]

PROGRAM AMD FINANCING (IN THOUSANDS OF DOLLARS)

	1973 actual	1974 est.	1975 est.
Financing: Budget authority			
Budget authority:			
Appropriation	4,000	4,000	4,000
Transfers to other accounts:			
Health professions education fund	−2,127	+2,250	−2,268
Nurse training fund	−1,873	−1,750	−1,732
Appropriation (adjusted)			

Biographical Sketch of Donald Chester Parks

Name: Donald Chester Parks.

Position: Acting Associate Administrator for Management, Health Resources Administration.

Birthplace and date: Seattle, Wash., June 11, 1933.

Education: B.A., University of Washington, Seattle, Wash., 1951–55; University of Alabama, Tuscaloosa, Ala., 1955–56; University of Tennessee, Knoxville, Tenn., 1956; and University of Kentucky, Lexington, 1956.

EXPERIENCE

Present: Acting Associate Administrator for Management: HRA.

1973: Acting Executive Officer, Bureau of Health Manpower Education.

1970–73: Assistant Director for Administration, Division of Physician and Health Professions Education, BHME.

1969–70: Assistant Director for Administration, Division of Health Manpower Educational Services, BEMT.

1967–69: Executive Officer, Division of Health Manpower Educational Services, BEMT.

1966–67: Program Analysis Officer, Welfare Administration, Department of Health, Education, and Welfare.

1966: Program Planning and Analysis Officer, Welfare Administration, Department of Health, Education, and Welfare.

1964–66: Executive Officer, Pesticides Program, DHEW, PHS.

1963–64: Management Analyst, Division of Radiological Health, BSS–EH, DHEW, PHS.

1961–63: Management Officer, NERHL, Division of Radiological Health, BSS–EH, DHEW, PHS.

1959-61: Management Assistant, Division of Radiological Health, VAA-EH, DHEW, PHS.
1957: Management Intern, Management Advisory Branch, BSS, DHEW, PHS.
Honoraries: Alpha Omicon Pi—(Political Science).
Awards: DHEW Superior Service Award, 1972; Superior Work Performance, 1963; and Quality Increase, 1968, EEO Award, 1972.
Training: Introduction to Automatic Data Processing, 1963; Modern Ideas to Concepts of Management, 1964; CSC Management and Organization: Ideas and Authors, 1965; Management Seminar, 1965; and Brookings Institute Seminar, 1971, 1972, 1973.

PAYMENT OF SALES INSUFFICIENCIES AND INTEREST LOSSES

Mr. Chairman and members of the committee: We are requesting $4 million for this appropriation, the same amount as last year. We have found for the past 3 years, that this amount will cover the mandatory operating costs that must be funded in accordance with the Public Health Service Acts and the Government Corporation Control Act. These operating costs are interest payments to the Treasury, interest payments to the Government National Mortgage Association, and cancellation payments to health professions schools.

The Public Health Service Act authorizes the Federal Government to pay the difference between the interest paid by the student to his school and the interest payable by the schools to the Government National Mortgage Association and to the Treasury. In addition, Federal payment is authorized to be paid to schools to cover cost of loan cancellations as provided for under the loan cancellation provisions of the Public Health Service Act.

These two funds—the Health Professions Education Fund and the Nurse Training Fund—have 1968–70 provided $46,163,000 in loans to students in schools of medicine, dentistry, optometry, podiatry, osteopathy, pharmacy, veterinary medicine, and nursing.

The students repay these loans with interest to the institutions and the payments are then repaid to the Secretary for deposit in the revolving funds. However, as these funds have been in operation only since 1968, repayment of loans and interest by students remains insignificant, since students do not pay on loans until education is completed and other deferments are utilized.

In fiscal year 1975, therefore, the $4 million requested will provide for the following:

(1) Payment to the Treasury Department of $1,874,000 interest on appropriated funds loaned to the schools.

(2) Payment to the Government National Mortgage Association of $929,000 interest due to holders of participation certificates issued by the Government National Mortgage Association and backed by notes given to the Secretary by the schools.

(3) Estimated payment to the schools of $1,197,000 arising from the forgiveness and cancellation benefits in the act relating primarily to the employment of graduates in an area of public benefit.

I will be most happy to answer any questions.

Mr. FLOOD. The $4 million for payment of sales insufficiencies and interest losses, is a mandatory appropriation. Right?

Mr. PARKS. Right.

AUTHORIZING LEGISLATION

Mr. FLOOD. With the authorizing legislation for the awarding of loans under section 744 and 827 of the Public Health Service Act expiring on June 30, 1974, why is there a need for this appropriation in fiscal year 1975?

Mr. PARKS. We participated in sales, through GNMA and those are long-term notes on which we are required to make payments. In addition we are required to pay to the Treasury interest on appropriated money loaned to students which technically could run until 1999.

Mr. FLOOD. What is the legislative authority which permits the appropriation of funds for these purposes after June 30, 1974?

Mr. Parks. It is a continuing authority within the PHS Act in section 744(b) relating to health profession schools and in section 827(b) relating to nursing schools. These are special debt servicing sections and does not relate to the appropriation of money for student loans.

Mr. Flood. I want to have the record show that.

The amount you have requested has remained at the same level, $4 million, since fiscal year 1972. Do you believe that is the maximum amount required to carry out the provisions of the student loan program?

Mr. Parks. This money we are requesting relates only to certain required interest payments and in no way provides loan moneys to the students. The money is only to meet those interest cancellations, and forgiveness obligations of loans made previously.

CANCELLATION PROVISIONS

Mr. Flood. Are more students taking advantage of that cancellation provision in the law by serving in these designated manpower shortage areas?

Mr. Parks. Each year a few more are coming in. It hasn't been in significant numbers. The new forgiveness provisions that were provided by the Health Manpower Act of 1971 provide a much greater foregiveness provision. We think there will be a greater rise but it will not affect these funds too much.

Mr. Flood. How much in this request do you have to cover cancellations which stem from these students going to these shortage areas? Put that in the record.

[The information follows:]

In fiscal year 1975 $1,197,000 is requested for cancellations. Based on fiscal year 1972 figures 99 percent or $1,185,000 will cover cancellations due to employment and 1 percent will cover cancellations due to death and disability.

Mr. Flood. Also for the record show how many students took advantage of the cancellation program provision in fiscal year 1973 and 1974. That is all we need from you.

Mr. Parks. We don't have the 1973-74 figures yet because the student has to participate for a year at least. We can give you up to 1972.

Mr. Flood. By the time this is printed you might have that.

Mr. Parks. The regional offices are processing the 1973 figures now.

[The information follows:]

Student loans can be cancelled for either of two reasons; employment in a shortage area or due to the death or disability of the individual. The following table indicates the number of students for which loans have been cancelled over a 3-year period.

Year	Total students	Reason for cancellation	
		Employment	Death or disability
1970:			
Physicians	6		6
Nurses	586	577	9
Subtotal	592	577	15
1971:			
Physicians	13	6	7
Nurses	1,796	1,789	7
Subtotal	1,809	1,795	14
1972:			
Physicians	16	7	9
Nurses	2,730	2,718	12
Subtotal	2,746	2,725	21

Mr. FLOOD. Are there questions?
Thank you very much.

JUSTIFICATION OF THE BUDGET ESTIMATES

Payment of Sales Insufficiencies and Interest Losses

Amounts Available for Obligation

	1974	1975
Appropriation	$4,000,000	$4,000,000
Estimated transfer to other accounts 1/	4,000,000	4,000,000
Health Professions Education Fund	(2,250,000)	(2,268,000)
Nurse Training Fund	(1,750,000)	(1,732,000)

1/ Distribution between Health Professions Education Fund and Nurse Training Fund may vary due to changing interest rate.

Health Professions Education Fund

Amounts Available for Obligation

	1974	1975
Receipts and reimbursements from non-Federal sources	$2,186,000	$2,190,000
Transferred from other accounts (estimate)	2,250,000	2,268,000
Unobligated balance, start of year	352,000	127,000
Other unobligated balances, end of year	-127,000	-127,000
Total, obligations	4,661,000	4,458,000

Obligations by Activity and Object

	1974	1975	Increase or Decrease
Cancellations	$350,000	$370,000	+$20,000
Interest	4,311,000	4,088,000	-223,000
Total, obligations	4,661,000	4,458,000	-203,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Nurse Training Fund

Amounts Available for Obligation

	1974	1975
Receipts and reimbursements from non-Federal sources......	$1,585,000	$1,585,000
Transferred from other accounts (estimate)................	1,750,000	1,732,000
Unobligated balance, start of year........................	364,000	229,000
Other unobligated balances, end of year...................	-229,000	-229,000
Total obligations...	3,470,000	3,317,000

Obligations by Activity and Object

	1974	1975	Increase or Decrease
Cancellations................	$825,000	$827,000	+$2,000
Interest.....................	2,645,000	2,490,000	-155,000
Total obligations........	3,470,000	3,317,000	-153,000

Summary of Changes

1974 Appropriation	$4,000,000
1975 Request	$4,000,000
Net change	---

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Cancellations	---	$1,175,000	---	+$22,000
Total, increases	---	---	---	+22,000
Decreases:				
A. Built-in:				
1. Payment to Treasury	---	1,896,000	---	-22,000
Total, decreases	---	---	---	-22,000
Total, net change	---	---	---	---

Explanation of Changes

Increases:

The $22,000 is needed for reimbursements to schools for estimated loan repayments cancelled under section 744(b) and 827(b) of the Public Health Service Act.

Decreases:

The decrease in interest owed to the Treasury results from a reduction in loans outstanding.

Authorizing Legislation

Legislation	1975 Authorized	1975 Appropriation Requested
Public Health Service Act:		
Payments to Schools to Cover Certain Costs Incurred in Making Student Loans from Borrowed Funds:		
Section 744(b)--Health professions schools......	Indefinite	$2,268,000
Section 827(b)--Schools of Nursing..............	Indefinite	1,732,000

Appropriation

Section 744(b). If a school borrows any sums under this section, the Secretary shall agree to pay to the school (1) an amount equal to 90 per centum of the loss to the school from defaults on student loans made from such sums, (2) the amount by which the interest payable by the schools of such sums exceed the interest received by it on student loans made from such sums, (3) an amount equal to the collection expenses authorized by section 740(b)(3) to be paid out of a student loan fund with respect to such sums, and (4) the amount of principal which is cancelled pursuant to section 741(d) or (f) with respect to student loans made from such funds. There are authorized to be appropriated without fiscal year limitations such sums as may be necessary to carry out the purposes of this sub-section.

Section 827(b). If a school of nursing borrows any sums under this section, the Secretary shall agree to pay to the school (1) an amount equal to 90 per centum of the loss to the school from defaults on student loans made from such sums, (2) the amount by which the interest payable by the school of such sums exceed the interest received by it on student loans made from such sums, (3) an amount equal to the amount of collection expenses authorized by section 822(b)(3) to be paid out of a student loan fund with respect to such sums, and (4) the amount of principal which is cancelled pursuant to section 823(b)(3) or (4) with respect to student loans made from such sums. There are authorized to be appropriated without fiscal year limitations such sums as may be necessary to carry out the purposes of this sub-section.

Payment of Sales Insufficiencies and Interest Losses

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
1968	$250,000	$250,000	$250,000	$250,000
1969	200,000	200,000	200,000	200,000
1970	957,000	957,000	957,000	957,000
1971	3,083,000	3,083,000	3,083,000	3,083,000
1972	4,000,000	4,000,000	4,000,000	4,000,000
1973	4,000,000	4,000,000	4,000,000	4,000,000
1974	4,000,000	4,000,000	4,000,000	4,000,000
1975	4,000,000			

Payment of Sales Insufficiencies and Interest Losses

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	---	---	---	---	---	---
Other expenses........	---	$4,000,000	---	$4,000,000	---	---
Total.......	---	4,000,000	---	4,000,000	---	---

INTRODUCTION

This appropriation provides for those mandatory interest payments to the Treasury Department and the Government National Mortgage Association which arise from operation of the two student loan revolving funds, the Health Professions Education Fund and the Nurse Training Fund. Under the basic legislation, funds may be loaned to health professions schools and schools of nursing for use by the schools in making loans to students, Schools borrowing funds execute a note payable for the amount of the loan. Participation certificates (backed by these notes) may be sold to private investors by the Government National Mortgage Association so that the funds may be replenished. Interest on appropriated funds loaned to the schools must be paid to the Treasury Department, interest must be paid to the private investors, and payments must be made to schools for loan cancellations and forgiveness.

Fiscal Year 1974

The appropriation for fiscal year 1974 for sales insufficiences and interest losses is $4,000,000. Included is $1,896,000 for payment of interest to the Treasury Department of $30,336,000 on appropriated funds loaned to schools during fiscal year 1968 through 1971 to capitalize their student loan funds. Also included is $929,000 for interest due to holders of $14,569,000 of participation certificates issued by the Government National Mortgage Association. In addition, $1,175,000 is provided for payment to schools for cancellations of principal as provided for in section 744(b), Title VII and section 827(b), Title VIII of the Public Health Service Act, as amended.

Plans, Fiscal Year 1975

In fiscal year 1975, payment of interest to the Treasury and to the Government National Mortgage Association will continue. In addition, students will continue to take advantage of the forgiveness benefits of the loan fund act.

Title VII, part C and Title VIII, part B of the Public Health Service Act, established a revolving fund from which health professions schools and schools of nursing could borrow in order to provide loans to their students. Public Law 89-751, the Allied Health Professions Personnel Training Act of 1966, amended the Public Health Service Act to authorize the Federal Government to pay the difference between the interest paid by students to the schools and the interest payable by the schools to the Government National Mortgage Association and the Treasury.

The fiscal year 1975 request of $4,000,000 will provide the following Federal payments:

$2,639,000--Payment of Interest Differential
($1,769,000)--Health Professions Education Fund
($870,000)--Nurse Training Fund

$164,000--Payment of Insufficiencies
($129,000)--Health Professions Education Fund
($35,000)--Nurse Training Fund

$1,197,000--Payment of Cancellation
($370,000)--Health Professions Education Fund
($827,000)--Nurse Training Fund

Interest Losses (Differential)

(1) Federal payment to the United States Treasury which represents the difference between the United States Treasury interest rate and that paid by the schools on an estimated $29,972,000 (Health Professions Education Fund, $18,668,000 and Nurse Training Fund, $11,304,000) loaned to schools.

$1,874,000--Payment of Interest Differential to Treasury
($1,167,000)--Health Professions Education Fund
($707,000)--Nurse Training Fund

(2) Federal payment to the Government National Mortgage Association which represents the 5.25 percent interest rate on $14,569,000 ($11,459,000, Health Professions Education Fund, and $3,110,000, Nurse Training Fund) worth of paper (pledged notes) held by the Government National Mortgage Association as collateral for participation certificates sold to private investors.

$765,000--Payment of Interest to Government National Mortgage Association
($602,000)--Health Professions Education Fund
($163,000)--Nurse Training Fund

Insufficiencies

Federal payment to the Government National Mortgage Association which represents the difference between the 5.25 percent interest rate earned by the student loan paper (promissory notes) and the 6.38 percent rate by the Government National Mortgage Association on $14,659,000 worth of paper (participation certificates) held by the public.

$164,000--Payment of Insufficiencies
($129,000)--Health Professions Education Fund
($35,000)--Nurse Training Fund

Cancellations

Federal payment to Health Professions schools and Schools of Nursing for loan cancellations under section 744(b), Title VII and section 827(b), Title VIII of the Public Health Service Act. These loans are cancelled by either the death or permanent and total disability of the borrower or the borrower's willingness to serve in an area designated by the Secretary as being eligible for loan cancellations.

$1,197,000--Payment of Cancellations
($370,000)--Health Professions Education Fund
($827,000)--Nurse Training Fund

THURSDAY, APRIL 4, 1974.

OFFICE OF THE ASSISTANT SECRETARY OF HEALTH

SALARIES AND EXPENSES

WITNESSES

DR. HENRY E. SIMMONS, DEPUTY ASSISTANT SECRETARY FOR HEALTH
JOHN H. KELSO, DIRECTOR, OFFICE OF REGIONAL OPERATIONS, PHS
RUPERT MOURE, EXECUTIVE OFFICER, PHS
JOHN C. DROKE, DIRECTOR, OFFICE OF ADMINISTRATIVE MANAGEMENT, PHS
WILLIAM E. MULDOON, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, OAM/PHS
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET

Object Classification (in thousands of dollars)

	Identification code 09-37-0367-0-1-653	1973 actual	1974 est.	1975 est.
	Direct obligations:			
	Personnel compensation:			
11.1	Permanent positions	8,935	9,552	17,494
11.3	Positions other than permanent	383	372	422
11.5	Other personnel compensation	110	74	147
	Total personnel compensation	9,428	9,998	18,063
12.1	Personnel benefits: Civilian	935	978	12,777
21.0	Travel and transportation of persons	239	222	1,207
22.0	Transportation of things	24	24	72
23.0	Rent, communications, and utilities	656	587	2,005
24.0	Printing and reproduction	298	162	178
25.0	Other services	1,656	875	17,613
26.0	Supplies and materials	107	67	127
31.0	Equipment	25	32	257
	Total direct obligations	13,368	12,945	52,299
	Reimbursable obligations:			
	Personnel compensation:			
11.1	Permanent positions	44	68	2,152
11.3	Positions other than permanent	---------	---------	52
11.5	Other personnel compensation	---------	---------	12
	Total personnel compensation	44	68	2,216
12.1	Personnel benefits: Civilian	3	7	187
21.0	Travel and transportation of persons	1	130	260
23.0	Rent, communications, and utilities	---------	3	5
24.0	Printing and reproduction	---------	---------	28
25.0	Other services	---------	20	10
	Contracts	---------	---------	24,455
26.0	Supplies and materials	---------	1	20
31.0	Equipment	---------	2	50
	Total reimbursable obligations	48	231	27,231
99.0	Total obligations	13,416	13,176	79,530

Personnel Summary

Total number of permanent positions	545	512	968
Full-time equivalent of other positions	29	33	59
Average paid employment	572	543	1,010
Average GS grade	9.3	9.9	10.1
Average GS salary	$15,681	$17,176	$17,240
Reimbursable:			
Average paid employment	3	3	108
Average GS grade	12.9	12.9	11.5
Average GS salary	$22,000	$22,000	$19,907

Program and Financing (in thousands of dollars)

	Identification code 09-37-0367-0-1-653	1973 actual	1974 est.	1975 est.
	Program by activities:			
	Direct program:			
	1. Regional office central staff	---------	---------	7,253
	2. Program direction and support services	13,423	12,945	14,146
	3. Professional standards review organizations	---------	---------	30,900
	Total direct program	13,423	12,945	52,299
	Reimbursable program:			
	2. Program direction and support services	48	231	231
	3. Professional standards review organizations—trust funds	---------	---------	27,000
	Total reimbursable program	48	231	27,231
	Total program costs, funded [1]	13,471	13,176	79,530
	Change in selected resources (undelivered orders)	−55	---------	---------
10	Total obligations	13,416	13,176	79,530
	Financing:			
	Receipts and reimbursements from:			
11	Federal funds	−48	−231	−231
13	Trust funds	---------	---------	−27,000
25	Unobligated balance lapsing	35	---------	---------
	Budget authority	**13,403**	**12,945**	**52,299**

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[1] Includes capital outlay as follows: 1973, $25 thousand; 1974, $50 thousand; 1975, $275 thousand.

NOTES

Includes $29.249 in 1975 for activities previously financed from:

	1973	*1974*
Health Services Administration	5,743	6,140
Food and Drug Administration	585	585
Alcohol, Drug Abuse, and Mental Health Administration	371	371
Social and Rehabilitation Service	-----	16,075
National Cancer Institute	193	193
National Heart and Lung Institute	77	77
National Institute of Dental Research	31	31
National Institute of Arthritis, Metabolism, and Digestive Diseases	63	63
National Institute of Neurological Diseases and Stroke	63	63
National Institute of Allergy and Infectious Diseases	60	60
National Institute of General Medical Sciences	44	44
National Institute of Child Health and Human Development	73	73
National Institute of Environmental Health Sciences	30	30
National Library of Medicine	66	66
Center for Disease Control	35	35
Health Resources Administration	265	265
Departmental management	4,448	5,078
Excludes $6.059 in 1975 for activities transferred to:		
Health Resources Administration	-----	1,989
Health Services Administration	-----	3,998
Office of the Director, NIH	-----	72

Comparable amounts for 1973 ($5.396) and 1974 ($6.059) are included above.

	Budget authority:			
40	Appropriation	13,126	12,000	52,299
41	Transferred to other accounts	−5	---------	---------
42	Transferred from other accounts	282	---------	---------
43	**Appropriation (adjusted)**	**13,403**	**12,000**	**52,299**
46.20	**Proposed transfer for civilian pay raises**	---------	**871**	---------
46.30	**Proposed transfer for military pay raises**	---------	**74**	---------
	Relation of obligations to outlays:			
71	Obligations incurred, net	13,368	12,945	52,299
72	Obligated balance, start of year	1,035	1,214	1,258
74	Obligated balance, end of year	−1,214	−1,258	−12,153
77	Adjustments in expired accounts	−197	---------	---------
90	Outlays, excluding pay raise supplemental	12,992	11,999	41,361
91.20	Outlays from civilian pay raise supplemental	---------	828	43
91.30	Outlays from military pay raise supplemental	---------	74	---------

Mr. FLOOD. We have the Office of the Assistant Secretary for Health, Salaries, and Expenses, also known as S. & E. The presentation will be made by Dr. Henry E. Simmons, Deputy Assistant Secretary for Health.

We have your biographical sketch here, Doctor, which we will place in the record.

[The document follows:]

BIOGRAPHICAL SKETCH OF HENRY E. SIMMONS, M.D.

Name: Henry E. Simmons, M.D.

Position: Deputy Assistant Secretary for Health.

Birthplace and date: Donora, Pa., January 16, 1930.

Education: University of Pittsburgh, 1951, Bachelor of Science; University of Pittsburgh, 1957, Doctor of Medicine; and Harvard University, 1965, Master of Public Health.

EXPERIENCE

Present: Deputy Assistant Secretary for Health; Director, Office of Professional Standards Review; and Clinical Associate Professor of Medicine, George Washington University.

1970–73: Director, Bureau of Drugs, Food and Drug Administration.

1968–70: Coordinator for Health and Medical Affairs, Booz, Allen & Hamilton, Inc.

1964–68: Consultant in Rheumatic Diseases and Internal Medicine, Tufts-New England Medical Center Hospitals, Boston, Mass.

1961–64: Private practice, Lexington and Boston, Mass.

1961–58: Resident in Internal Medicine, Tufts-New England Medical Center, Boston, Mass.

1958–61: Intern, University of Chicago Clinics, Chicago, Ill.

Association memberships: Member of the Board of Governors, American College of Physicians; Diplomate, American Board of Internal Medicine; Member, American Rheumatism Association; Member, American Public Health Association; Member, American Society of Internal Medicine; and Member, Alpha Omega Alpha.

Dr. SIMMONS. I would like to introduce Mr. Charlie Miller, the Deputy Assistant Secretary, Budget; John H. Kelso, the Director of our Office of Regional Operations; Mr. William E. Muldoon, Director, Office of Resource Management; Rupert Moure, Executive Officer of the Public Health Service; and John C. Droke, Director of the Office of Administrative Management.

Mr. FLOOD. I see you have a prepared statement here, Mr. Secretary. You may proceed.

Dr. SIMMONS. Thank you.

OPENING STATEMENT

Mr. Chairman and members of the committee, I am pleased to appear before you today to present the 1975 budget request for the appropriation supporting those activities directly under the Office of the Assistant Secretary for Health. This is a new appropriation which was established as a result of the reorganization of the Public Health Service. It finances the activities of the regional health administrators' central staff, the program direction and administrative functions, and our nationwide professional standards review organization program.

PROGRAM DIRECTION AND SUPPORT SERVICES

As part of the reorganization of the Public Health Service, the Assistant Secretary for Health was given the added responsibilities as the line manager of the six health agencies in addition to the previous role as the staff adviser to the Secretary, on health matters. In order to discharge our responsibilities, we have set in place a fundamentally new management structure necessary to carry out our mission. A staff of approximately 500 were assembled by transfer of existing program direction and management personnel. I would like to take a few moments to discuss the activities of this staff.

Perhaps the greatest contribution that this office can make to the health activities of this country is to develop a coordinated national health program for the Federal Government. With the changing role of the Federal Government in the health area, it is important that we develop a national health strategy, that we evaluate our ongoing health programs to meet the changing needs of our population and that we assure that our current programs do not overlap each other. These functions are the responsibilities of the Office of Policy Development and Planning, and the Office of Program Operations. It is through these Offices that we also coordinate our efforts with those of the Social Security Administration and the Social and Rehabilitation Service on such matters as medicare, medicaid, health insurance planning, and development of professional standards review organizations.

Because of the heavy involvement of certain health programs with other agencies in the Department and the Federal Government, we have a small specialized staff involved in the areas of population affairs, nursing home affairs, and international health. This group coordinates all of the health activities within the Public Health Service that fall within their program areas, as well as providing a focal point for dealing with other Federal agencies who have related programs.

Through the Office of Administrative Management, leadership and management services are provided to all the health agencies in such areas as financial management, grants and contracts administration, personnel policy, and management systems. We have established an Office of Regional Operations through which we are providing leadership to the over 1,300 personnel in the regional offices.

The 1975 budget includes $14,146,000, an increase of $682,000 over the 1974 comparable level, to support the program direction and management support services. All of this increase is required for mandatory items for the continuations of the 1974 functions.

REGIONAL OFFICE CENTRAL STAFF

One of the changes we have brought about is the establishment of the regional health administrators as the principal health officials in the HEW regional offices. The budget of the Office of the Assistant Secretary for Health includes the support of the regional health administrators and their immediate staff.

In 1975, $7.3 million are requested to support the salaries and related expenses of the 250 health personnel located in the regional offices. This staff provides the technical and administrative support and policy guidance for health programs administered through the regional offices. Technical assistance and consultation are provided to States, local, and community organizations for the planning and evaluation of a wide variety of health programs, and for the administration of grants awarded in the regional offices. In addition, this staff is frequently called upon to participate with State and local agencies in the development and implementation of special health initiatives and activities for the department. The administrative support activities of this staff enable us to provide the overall management, planning, and evaluation services essential for the regional health administrators to coordinate all health functions in the regional geographic areas under their jurisdiction.

The increase of $1,344,000 included in this budget for the regional office central staff is for built-in costs for the continuation of essential technical and administrative services provided in 1974, including $1,201,000 to be transferred to the General Service Administration for space rental charges.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Included in this appropriation are funds for the professional standards review organization program which is being carried out through the office of the Assistant Secretary for Health.

As you know, the PSRO—professional standards review organization—program was authorized by the 1972 amendments to the Social Security Act. It is designed to assure that the medical care delivered to medicare, medicaid, and maternal and child health program recipients is necessary, of acceptable quality, and provided in the most appropriate setting. It is a quality assurance program, involving local practicing physicians in the ongoing review and evaluation of the medical services delivered by their peers. The concept underlying the legislation is that peer review at the local community level is the soundest method for assuring quality medical care and the appropriate use of health care resources and facilities.

I should now like to review the progress we have made in implementing the program. In March, the Secretary designated 203 geographic areas in which PSRO's are to be established. The Department is accepting applications for contracts from qualified organizations to plan PSRO's, to begin operation of PSRO's on a conditional basis, and to fund statewide organizations to provide support services to local PSRO's.

In addition, we are working closely with professional medical organizations toward the development of appropriate standards of care that individual PSRO's may use or modify in developing peer review programs for their own areas. And we are arranging for a number of contractual studies to determine what information and management systems local PSRO's will require to carry out their standard-setting and peer review responsibilities.

We anticipate by the end of 1975 that agreements will have been negotiated with approximately 120 local PSRO's. To make it possible to reach this objective, we are requesting 316 positions and $57.9 million, an increase of 175 positions and $24.2 million over 1974. A total of $51.5 million of this request will be used to reimburse local PSRO's and State councils. The remaining funds—$6.4 million—and all of the requested positions will be used to provide program support.

In summary, the budget request for this appropriation is $79,299,000, a net increase of $26,256,000 over 1974. Aside from the mandatory increases of $3,491,000, the remaining increase of $22,765,000 is for the expansion of the PSRO program. Of the total request of $79,299,000, $27 million will be transferred from the social security trust funds for the PSRO program.

Now, Mr. Chairman, if there is any way in which we can further assist the committee in its examination of the activities and request for the Office of the Assistant Secretary for Health, we will be pleased to do so.

Mr. Flood. Thank you very much, Mr. Secretary.

BUDGET REQUEST

You are requesting $52,299,000 for the year 1975. That is a $39.3 million increase over the 1974 appropriation. Is that right?

Dr. Simmons. Yes.

FUNDING THE OFFICE OF THE ASSISTANT SECRETARY

Mr. Flood. In addition to the direct appropriation of $52.3 million, you are requesting the transfer of $27 million from the "trust funds. That will give the Office of the Assistant Secretary for Health a total of $79.3 million in available funds for fiscal year 1975, is that correct?

Dr. Simmons. Yes, sir.

Mr. Flood. These are what are known as leading questions.

Of this $79.3 million to be available in 1975, how much is to be used in support of the Professional Standards Review Organizations, the PSRO's? Since I have defined it, we can refer to them from now on as PSROs.

Dr. Simmons. $57.9 million of that total.

PROFESSIONAL STANDARD REVIEW ORGANIZATION

Mr. Flood. Will all of the trust fund money which I mentioned before be used to support the PSRO program?

Dr. Simmons. Yes, it will be used to support the review activities of the 203 PSRO's throughout the country.

Mr. Flood. How many PSRO's have you funded to date?

Dr. Simmons. To date, we have funded a PSRO statewide support center in your State, the Pennsylvania State Medical Society. It is the first funded activity in the whole program. We funded it a few days ago.

Mr. Flood. I am not surprised.

Go ahead.

NATIONAL CONFERENCE ON PSRO'S

Dr. Simmons. We had a national conference here in Washington that ended yesterday, and we had 400 people from throughout the country who were interested in establishing PSRO's. They are now back in their home grounds preparing the applications to come in for this funding cycle.

Mr. Flood. From how many States?

Dr. SIMMONS. There were 400 people representing the whole country. We anticipate that we will probably get more than 100 applications from throughout the country for this fiscal year.

Mr. FLOOD. How many do you intend to fund by June 30, 1974?

Dr. SIMMONS. We could well be between 50 and 100 PSROs, conditional and planning.

Mr. FLOOD. In fiscal year 1975, how many more do you plan to fund?

Dr. SIMMONS. There are only 203 that we can have in the whole program, so there would be from 153 to 103 more.

PSRO LEVEL OF SUPPORT

Mr. FLOOD. What would be the average level of support for each PSRO?

Dr. SIMMONS. Mr. Chairman, that is very hard to know. As you know, we have never run exactly this kind of entity. We are estimating that it would be between $300,000 and $400,000, on the average, for PSROs at the early stage of their development. A big one in Manhattan could cost several million dollars. A little one in Lycoming County could be much less. On the average, we are saying it could be between $300,000 and $400,000.

Mr. FLOOD. At what point do you plan to have all the 203 designated PSROs in operation?

Dr. SIMMONS. That is impossible to answer because it depends upon whether the profession will come forward and request them. Given the interest we saw that I just mentioned——

Mr. FLOOD. All things being equal.

Dr. SIMMONS. All things being equal, I think there is a very real possibility that by the first of 1976 there will be 203 PSROs designated. They will not be operational, but they will be designated.

Mr. FLOOD. How long will it take for a designated PSRO area to become fully operational?

Dr. SIMMONS. Allegheny County might be funded as a conditional PSRO to start review activities any time within the next 3 to 9 months.

Mr. FLOOD. The PSRO area will be the County of Allegheny?

Mr. SIMMONS. They could be conducting PSRO review in from 3 to 9 months because they are already doing work similar to this, you see. The State of Utah probably will be operational in the next month or month and a half.

STATE SUPPORT CENTERS

Mr. FLOOD. In that case, would the State be the area?

Dr. SIMMONS. No. The State of Pennsylvania will have a State-support center that provides common technical/administrative resources to the 12 PSRO's throughout the State.

Mr. FLOOD. You mentioned Utah. Under the circumstances, the whole State there would be actually the operational area?

Dr. SIMMONS. Right.

Mr. FLOOD. For obvious reasons, Pennsylvania will have a dozen or more PSRO's. However, the State setup would be supervisory, in a sense?

Dr. SIMMONS. The support center.

WILL PSRO'S BECOME SELF-SUPPORTING

Mr. FLOOD. Will these PSRO's be able to support themselves after they become operational?

Dr. SIMMONS. In which way do you mean, Mr. Chairman? You mean can they do everything that needs to be done themselves?

Mr. FLOOD. It appears that the Federal Government will be supplying a pretty long-term support to the program. I would like to know, will one of these PSRO outfits be able to support themselves after they become operational, not all of them, but one?

Dr. SIMMONS. They never can achieve that status, because they charge no fee for their service. In other words, they are not in a fee-for-service system. They are providing a service which determines how we are going to pay the other $24 billion funded through medicare/medicaid and other funds through national health insurance, if we get it. There is no fee charged, so they cannot pay for themselves.

It is clear to us that they will certainly pay for their costs in the benefit they bring to the public and the profession. I do not know how you put a dollar value on it.

ANNUAL COST OF PSRO PROGRAMS

Mr. FLOOD. After all this is done and we have all these 203 designated PSRO areas operational, what do you estimate the annual cost of maintaining the program will then be?

Dr. SIMMONS. I cannot honestly give you a good answer to that.

Mr. FLOOD. Off the top of your head, within reason, an educated guess.

Dr. SIMMONS. I would say about $100 million, possibly. It depends a lot on how the data systems that currently exist get integrated into the program. That is a great deal of what final cost will be.

We intend to build on what exists, so we could well keep it at approximately $100 million.

USE OF EXISTING DATA SYSTEMS

Mr. FLOOD. That is true of so many different programs in this long-haired, flat-heeled hardware. You cannot do anything about it, of course.

Dr. SIMMONS. Yes, we can.

Mr. FLOOD. How?

Dr. SIMMONS. We can absolutely insist that the 203 PSRO's do not try to reinvent the wheel and we won't let them. We will require them to use existing systems.

Mr. FLOOD. You, within reason, will control the system.

Dr. SIMMONS. Yes, I think it is a very sensible program, but you are talking to a pretty biased observer.

Mr. FLOOD. I mentioned before, when I came in, that I had been at Defense Appropriations. When these computer things first started to come out, all this fancy hardware, we began them, you know. The first ones we set up were in Defense. The first one I saw was about as big as this room. You had to climb up on a ladder. Green and red and yellow lights went on. It did everything but play the Star Spangled Banner every time you pushed the button.

Now they are just as big as this table. You buy all this fancy hardware, and it is delivered on Saturday. Then on Monday the salesman comes around and says, "Now we have a new generation. Everything you bought is obsolete."

Don't get trapped in that. Because of what you have to do with the PSRO's over the long run, it will be so easy to get trapped into this new hardware which is so essential to you. It is your heart's blood. Watch that.

Dr. SIMMONS. We have built right into the PSRO manual, which we published just 2 weeks ago, that PSRO's will not be allowed to buy new data systems.

Mr. FLOOD. That will do it. That should do it.

Dr. SIMMONS. It could be a terrible waste if many new systems were installed.

NEED FOR LOCAL PHYSICIAN SUPPORT FOR PSRO'S

Mr. FLOOD. Out in the provinces, they do not know this, you know.

When Dr. Edwards testified here a few weeks ago, he told us that in order to receive support, a designated PSRO area must win the support of the practicing physicians in the area.

Dr. SIMMONS. Correct.

Mr. FLOOD. Suppose the physicians in the area decide not to support this PSRO, what do you do in that situation?

Dr. SIMMONS. The legislation already passed speaks to that. It says if that does not happen by 1976, the Secretary may set up something else.

I personally doubt that that is going to be the case any place, because there is too much advantage to the profession in the program for them to ignore it. I think that is what will happen.

CONSUMER INVOLVEMENT IN PSRO'S

Mr. FLOOD. Will the local PSRO groups involve consumers and the health care professionals from all levels of the health delivery system in the PSRO structure?

Dr. SIMMONS. We have recommended in the manual that each PSRO board include consumers in its membership, but the way the legislation is written, the actual review and standard-setting is reserved exclusively to professionals.

Mr. FLOOD. Do you think it important that consumers and health professionals other than M.D.'s participate in the PSRO program? It would appear to us that the involvement of other health professionals in this PSRO system is certainly necessary in order to effectively correct this problem within the whole health care system so they can be adequately represented.

Dr. SIMMONS. That is built in, too. For instance, the dentists, podiatrists, chiropodists, nurses, physical therapists—anyone who delivers care has to be in an advisory capacity to the PSRO to evaluate the services that they render. That is built into the legislation and our planning.

So, a dentist evaluates a dentist; a chiropodist, a chiropodist; an optometrist, an optometrist, as long as that is a covered service under medicare/medicaid.

The final judge is built into the legislation as the PSRO, but they must listen to the advice of those paraprofessionals and other professionals who provide the care. This is a fair system, I believe.

NATIONAL STANDARDS FOR CARE

Mr. Flood. Will you set national standards of acceptable care in order to assure a more effective use of the dollars that are to be expended for this health care?

Dr. Simmons. No; we will not. The legislation speaks very clearly to that. It says the PSRO criteria must be set by the local area. In other words, 203 PSRO's decide what their standard of care is to be.

NATIONAL PROGRAM

But the national program has the responsibility, with its advisory council, to let PSRO "*A*" know that PSRO "*B*" is getting the same result you are with much less morbidity and mortality and with less use of resources. What is the difference? They then have to study the reason why and change, if there is no acceptable reason. In fact, you would be interested, Mr. Chairman, that Dr. Virgil Slee, who runs a huge system in Michigan that is nationwide, the PAS system, collecting data from over the country, which has been in existence 15 years, tells us that if the Eastern region of the United States kept people the same length of time as the Midwestern region, for the same age, the same diagnosis and sex, there would be a $5 billion difference in health costs.

That is one of the things that needs to be explained as this program goes on. Why is the same disease treated differently? If there are good reasons, fine. If not, one of them should change.

That is one of the advantages of the PSRO after it becomes operational. It will identify and do something about this.

BUREAU OF QUALITY ASSURANCE

Mr. Flood. We had the Health Services Administration up here testifying on their budget. They requested support for an activity they called "Quality Assurance," which has 224 positions and $5,774,000 in fiscal year 1975. They told us that they were involved in this PRSO program in establishing medicare and medicaid quality of care standards. Is that correct?

Dr. Simmons. Yes; that is correct.

Mr. Flood. If they are involved in this PSRO activity, then why is there a need for 175 new jobs in your office for the PSRO program?

Dr. Simmons. There are two different kinds of things they are doing. That Bureau of Quality Assurance and its programs set health care standards for the whole medicaid and medicare program including the renal dialysis program. It sets standards for the hospitals and nursing homes in the country. It sets standards for the independent laboratories of the country. Also, it is involved in all the payment decisions in medicare/medicaid, and maternal and child health. The staff of the Bureau of Quality Assurance not only set these standards but help to insure that the standards are implemented by working with the State agencies which survey and certify these health care institutions. This is a part of the standard-setting activity which is in addition to the professional portion of the service for which PSRO itself is responsile.

That is an institutional service, a facility kind of standard-setting, including the renal dialysis program. PSRO is the professional service standard-setting activity.

NEED FOR NEW POSITIONS

Mr. **Flood.** If you were to get these additional 175 jobs, you would have a total down there of 316 people working in the PSRO program, plus the 224 they were talking about in the Quality Assurance program. It appears you will have 540 people working on this medical care standard-setting activity.

Dr. **Simmons.** Yes.

Mr. **Flood.** Tell me how the 316 people in your shop, in your committee office, will relate to the 224 people you have in the Bureau of Quality Assurance, in this same business, the PSRO standard-setting function.

Dr. **Simmons.** It is not the same kind of standard-setting. The Bureau of Quality Assurance is responsible for the standards in over 12,000 nursing homes, intermediate care facilities, skilled nursing facilities, 7,000 hospitals, all of the laboratories, all the renal dialysis programs that are about to be set up, and reviewing all the regulations under medicare/medicaid that have to do with physical standards other than the medical professional standards that PSRO is involved in.

So, it is a standard all right, but it is a different spectrum of the standards.

PSRO itself talks about the professional service rendered and the standard and evaluation of that. It is two different things. They are similar in that they are all standards.

RESPONSIBILITY FOR PSRO ACTIVITY

Mr. **Flood.** You have heard about Flood's spies over in Defense. I get all this information from all sorts of places. I understand that the Bureau of Health Insurance, over in the Social Security Administration, will have responsibility for the day-to-day management of the PSRO activity. Is that right?

Dr. **Simmons.** No; it is not.

Mr. **Flood.** Well, that's bad. I was going to ask you how many people are going to be assigned to that. I thought I had you over a barrel. There is something the matter with my spy system, I guess.

Dr. **Simmons.** No. They are just misinformed.

Mr. **Flood.** That is what I mean.

Dr. **Simmons.** Or else we are paying them more than you are.

PSRO POSITIONS IN REGIONAL OFFICES

Mr. **Flood.** That is something else. It was a good try, anyhow.

How many of the 316 PSRO jobs are going to be assigned to the regional offices?

Dr. **Simmons.** 130. There are 30 out there now.

TECHNICAL ASSISTANCE

Mr. **Flood**. How much of the PSRO budget will be spent to provide technical assistance to the PSRO's?

Dr. **Simmons**. A great deal of it.

Mr. **Flood**. How much of the budget will be earmarked for that? What kind of technical assistance is provided, and by whom is it provided?

KINDS OF TECHNICAL ASSISTANCE TO PSRO'S

Dr. **Simmons**. The kinds of technical assistance vary from educating the physicians and the public about PSRO, helping them develop a plan for review of care, helping them develop methodologies from reviewing care, helping them set the standards, helping recruit professional reviewers, helping provide common administrative systems, bylaws, information systems that they need, and then helping them in the actual coordination, one PSRO to another.

So, it is technical, administrative, professional kinds of assistance from "How many secretaries do you need and what should they be doing?" to "What kind of professionals do you need?" and what review mechanism they are to use to see whether that care was rendered according to standards and should be paid for. It is the whole range of kinds of technical assistance.

Mr. **Flood**. You have two different kinds of groups. You have the eager beavers, and then you have the ones that will drag their feet.

How much of this kind of help will be provided through the so-called contract system?

USE OF CONTRACTS

Dr. **Simmons**. Up until July of this year, we will be proceeding only on contracts. We want to switch to agreements after that because it is something we can get done faster and more efficiently. We are not geared up to use the agreement mechanism right now. Until the end of this fiscal year, we will use contracts exclusively.

Mr. **Flood**. What is the average dollar amount of a technical assistance contract?

Dr. **Simmons**. The Pennsylvania support ecnter is a quarter of a million dollars. The average PSRO in the early conditional phase we think will be about $300,000 to $500,000, depending on the size and the area they are going to review. That is a very rough estimate of the cost.

STAFFING OF REGIONAL OFFICES

Mr. **Flood**. In 1975, you are requesting $7.253 million to support 250 positions in the regional offices. Is this the total of the new federalism thrust in the health area, or will there be other positions in the regional offices concerned with health program?

Dr. **Simmons**. Yes; there will be, out of the individual programs within the agency, of course. For example, under the comprehensive health planning program, under the PSRO program, and under the maternal and child health program, there are regional people. Each of these Washington programs have positions out there to handle the regional element of their operation.

These positions are not included in our figure, which counts only the immediate staff of the 10 regional health administrators.

Mr. FLOOD. What will be the total number of the health staff in the regional setups?

Mr. SIMMONS. About 1,400.

Mr. FLOOD. For the record, will you provide the total health staff in the regional offices, by program, for fiscal years 1971 through 1975?

Dr. SIMMONS. All right.

Mr. Chairman, that will be difficult under our current——

Mr. FLOOD. I do not care about that. That is your headache.

Dr. SIMMONS. OK. I just wanted to be candid with you. Because of the way we are organized——

Mr. FLOOD. You can see why I want the years, 1971 and 1975. Sure, it will be tough.

[The information follows:]

REGIONAL OFFICE STAFF
F.Y. 1971 - F.Y. 1975 (Estimated)

	1971	1972	1973	1974	1975
Regional Office Central Staff	215	260	250	250	250
Alcohol, Drug Abuse and Mental Health Administration	86	100	125	125	125
Health Resources Administration:					
Comprehensive Health Planning	-	-	-	24	24
Health Manpower	61	61	69	270	270
Health Care Facilities	61	47	60	63	63
Regional Medical Programs	10	10	-	-	-
Health Statistics	-	-	-	-	25
Health Services Administration:					
Community Health Services*	163	182	224	312	312
Maternal & Child Health	77	77	77	48	48
Family Planning Services	35	50	54	67	55
Professional Standards Review Organizations	-	-	-	30	130
Health Service Corps	-	-	70	50	50
Health Maintenance Organizations	-	-	-	50	65
Emergency Medical Services	-	-	-	25	25
Emergency Health Services	19	55	20	-	-
Center for Disease Control:					
Disease Control	48	49	52	53	53
Environmental Health Services	-	33	10	10	10
Occupational Safety and Health	-	-	45	29	29
TOTAL	775	924	1056	1406	1534

* Includes Medical Care Standards Activities

DECENTRALIZED PROGRAMS

Mr. FLOOD. You state in your justifications that the regional health administrators, RHA's, are responsible for more than 40 decentralized health programs. Again for the record, we want a list of those decentralized programs, indicating to what extent, if any, the regions have responsibility and authority in their own right for making grants and contracts without the central office, Washington, making clearances under each program.

[The information follows:]

DECENTRALIZED HEALTH PROGRAMS AND EXTENT OF REGIONAL OFFICE AUTHORITY

The following programs are fully decentralized with all authority for approval and funding delegated to the regional health administrators:

Comprehensive health planning—Areawide grants (314(b)).

Comprehensive health planning—Grants to States (314(a)).

Comprehensive public health services—Formula grants (314(d)).

Crippled children's services (formula grants).

Crippled children's services (project grants).

Dental health of children.

Family planning projects.

Health care of children and youth.

Health facilities construction—Grants.

Health services development—Project grants—(314(e)).

Intensive infant care projects.

Maternal and child health service (formula grants).

Maternal and child health services (project grants).

Maternity and infant care projects.

Migrant health grants.

Health facilities construction—Loans and loan guarantees.

Mental health—Alcohol formula grants.

Family health centers.

Childhood lead-based paint poisoning control.

Urban rat control.

Disease control project grants.

Area health education centers.

Physicians assistants.

Operation MEDIHC

Grants for training in family medicine.

The following programs are partially decentralized with all responsibilities delegated to the regional health administrator except for a legislatively mandated requirement for National Advisory Council review:

Mental Health: Hospital improvement grants; hospital staff development grants; community mental health centers; community mental health centers construction; and children's services.

Health professions construction grants, loans, and interest subsidy.

Nursing construction grants, loans, and interest subsidy.

Dental health continuing education training grants.

Nursing special projects.

Health professions financial distress.

Special health career opportunity grants.

Health professions special project grants.

Dental TEAM program grants.

Grants for conversion of 2-year schools of medicine.

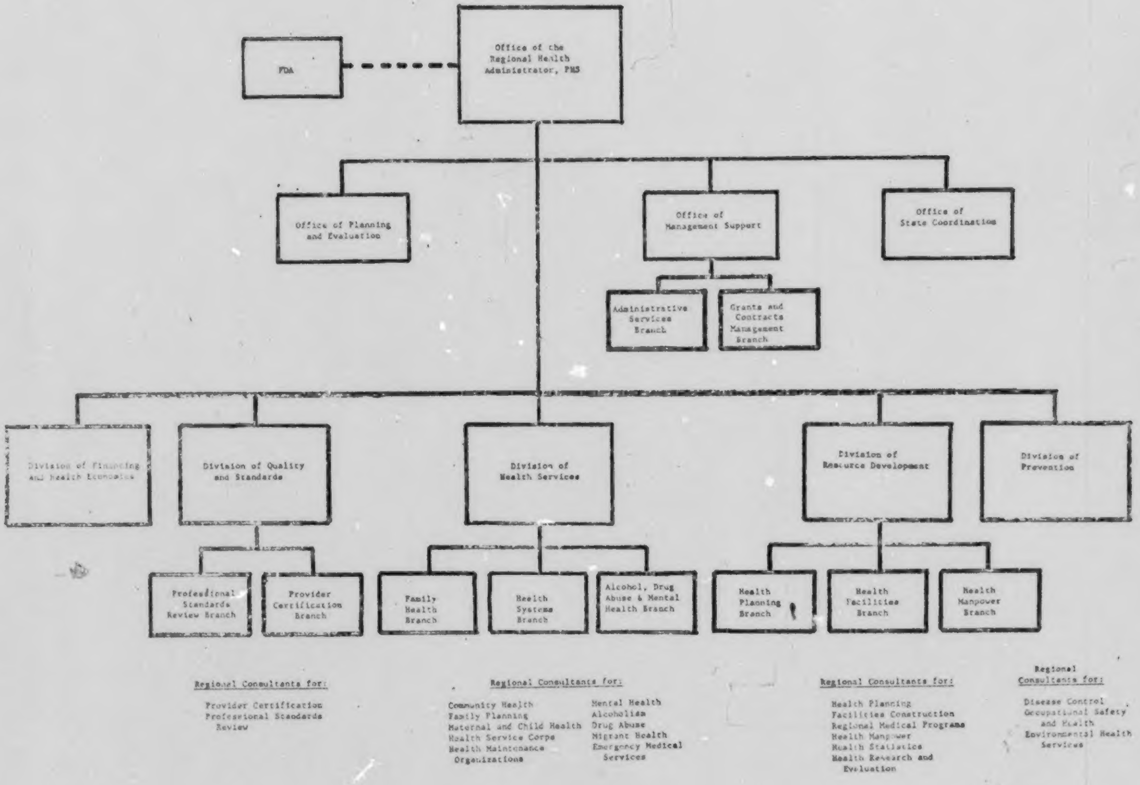
The following programs are partially decentralized with all responsibilities delegated to the regional health administrator except for the final calculation of the grant award:

Health professions capitation; student loans; scholarships; nursing student loans; and nursing scholarships.

REGIONAL OFFICE ORGANIZATION

Mr. Flood. Also for the record, let us have an organization chart. We want an organizational chart of a typical regional office. What kind of animal is it? What does it look like?

[The information follows:]


FDA
Office of the Regional Health Administrator, PHS
Office of Planning and Evaluation
Office of Management Support
Office of State Coordination
Administrative Services Branch
Grants and Contracts Management Branch
Division of Financing and Health Economics
Division of Quality and Standards
Division of Health Services
Division of Resource Development
Division of Prevention
Professional Standards Review Branch
Provider Certification Branch
Family Health Branch
Health Systems Branch
Alcohol, Drug Abuse & Mental Health Branch
Health Planning Branch
Health Facilities Branch
Health Manpower Branch
Regional Consultants for:
Provider Certification
Professional Standards Review
Regional Consultants for:
Community Health
Family Planning
Maternal and Child Health
Health Service Corps
Health Maintenance Organizations
Mental Health
Alcoholism
Drug Abuse
Migrant Health
Emergency Medical Services
Regional Consultants for:
Health Planning
Facilities Construction
Regional Medical Programs
Health Manpower
Health Statistics
Health Research and Evaluation
Regional Consultants for:
Disease Control
Occupational Safety and Health
Environmental Health Services

Mr. FLOOD. When you give birth to one of these things around here, we must do this. Believe me, this is a record that will be read and you have an audience waiting for the questions I have just asked you and the answers you are to prepare for the record.

PROGRAM DIRECTION AND SUPPORT SERVICES

Mr. FLOOD. You are requesting $14 million and 507 positions for program direction and support purposes.

Also for the record, we want a breakdown of that by functional area. By that I mean planning, accounting, et cetera, the positions, the jobs, and the dollars, and, of course, a brief description of the services performed for each area.

[The information follows:]

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Immediate Office (19 positions), $592,000:

Function: The Assistant Secretary for Health is the principal adviser and assistant to the Secretary of DHEW on health policy and all health-related activities in the Department. He is responsible for the direction of the health agencies of the Department, for providing leadership and policy guidance for health-related activities throughout the Department, and for maintaining relationships with other governmental and private agencies concerned with health.

Office of Administrative Management (253 positions), $6,798,000:

Function: Advises and assists the Assistant Secretary for Health and the Executive Officer of the Public Health Service on internal management issues, priorities, and policies. The offices which constitute the major elements of the Office of Administrative Management include:

Office of the Director (14 positions), $404,000:

Function: Provides leadership, coordination, and review of health-wide policy and programs involved in financial management, personnel management, management systems and studies, and administrative management.

Office of Resource Management (140 positions), $3,648,000:

Function: Serves as the principal resource within the Public Health Service on all phases of financial management inherent in the operation of the health agencies, directs an integrated operational planning process for health activities, serves as focal point for overall policy and fiscal management of contracts and grants activities, and serves as the principal resource on all phases of facility management affecting the health agencies.

Office of Personnel Management (53 positions), $1,441,000:

Function: Serves as the principal adviser in Health for personnel management and training activities, provides leadership and direction of the personnel management programs embracing the Commissioned Corps and Civil Service personnel, and coordinates personnel management activities of the health agencies with other governmental agencies.

Office of Organization and Management System (46 positions), $1,305,000:

Function: Serves as the principal adviser on all health organization and management activities, develops healthwide policies for organization, computer, and management systems, and reviews major agency management systems, procedures, and activities in terms of overall effectiveness and efficiency.

Office of Policy Development and Planning (75 positions), $2,270,000:

Function: Serves as the principal adviser to the Assistant Secretary for Health concerning the development of a national health policy; coordinates health policy development and research, planning, and program evaluation activities of the Public Health Service; and provides overall guidance for policy analysis and research, planning, and evaluation activities throughout the health agencies.

Office of Program Operations (30 positions), $892,000:

Function: Serves as the principal adviser to the Assistant Secretary for Health concerning the resolution of operating problems and monitoring implementation of program policies and objectives. Analyzes the medical and scientific aspects of health programs, assesses the implications of current policies, and reviews and recommends approval of new or revised policies and regulations when needed.

Office of Regional Operations (35 positions), $1,055,000:

Function: Serves as the principal staff adviser to the Assistant Secretary for Health on matters pertaining to the operation and management of regional offices, insures implementation of health programs, policies, and operational guidelines to the regions, and serves as the focal point for managing healthwide decentralization activities. Provides an overview of the interrelated activities of the health agencies conducted at the regional level.

Executive Secretariat (24 positions), $484,000:

Function: Assigns, controls, and coordinates communication flowing through the Office of the Assistant Secretary for Health, follows up on action items that result from meetings of the Assistant Secretary, establishes procedures for preparation of written correspondence, and manages a rapid communication system between the Office of the Assistant Secretary and the health agencies.

Office of Public Affairs (10 positions), $301,000:

Function: Serves as the focal point for major public affairs activities of the Public Health Service and provides overall coordination of the public affairs responsibilities of the six health agencies.

Office of International Health (22 positions), $638,000:

Function: Provides assistance and guidance on the international health activities of the Department, prepares analyses of selected international health policies and programs for the Department of State, and maintains liaison with institutions and organizations involved in international health matters.

Office of Population Affairs (10 positions), $269,000:

Function: Advises on programs of national importance in the fields of population dynamics, fertility, sterility, and family planning, and coordinates and directs population and family planning activities within the Public Health Service and other agencies of the Department.

Office of Nursing Home Affairs (13 positions), $334,000:

Function: Serves as the departmental focal point for managing nursing home affairs and directs and coordinates nursing home activities in both the health and nonhealth agencies.

Office of Drug Abuse Prevention (4 positions), $166,000:

Function: Serves as the principal departmental contact with other governmental units dealing with drug abuse issues; receives, refers, and follows up on requests from other Government agencies.

Office of Equal Employment Opportunity (7 positions), $202,000:

Function: Serves as the principal adviser to the Assistant Secretary for Health on all equal employment opportunity matters, develops and recommends for adoption health agencywide equal employment opportunity policies and goals, and provides leadership, direction, and technical guidance to the health agency equal employment opportunity officers.

Office of Health Legislation (5 positions), $145,000:

Function: Coordinates and directs legislative matters affecting health activities of the Department and the Public Health Service and provides liaison services between the Public Health Service and the Assistant Secretary for Legislation.

Mr. Flood. In the recent reorganization you are going through, you transferred several million dollars from the agencies—National Institutes of Health, HSA—into your office for centralized administrative support.

Tell me which services you now provide the agencies that they no longer will perform for themselves.

Dr. SIMMONS. We establish overall Public Health Service policy for the six health agencies in areas such as: planning, budgeting, administration, health strategy, evaluation, grants policy, and overall coordination among the Public Health Service agencies.

Mr. FLOOD. On the one hand, there is considerable discussion about decentralization, the greatest thing since sliced bread. On the other hand, you collect all these people into one office and all these operations that they no longer will do for themselves, but you are going to do.

I want to be sure this is nailed down, because somebody will ask me.

Dr. SIMMONS. The reason it is hard to answer the question, Mr. Chairman, is that every entity has to do some planning. Every entity has to do some personnel work. There are levels of detail at which that is done. In a 46,000-man organization, there must be a big, broad plan and an agency plan.

Mr. FLOOD. You are restating the question. I know that. That is why I asked you the question.

Do any of your people want to add to what you have just said? I would like to hear something now, if anybody wants to add to it. I know about the phrase, "Never volunteer." We would like to know. This is a new thing.

For the record, you can take a look at it and develop it. That will concern a lot of people. Why do you want to decentralize to regional offices and at the same time give all these jobs back to "Big Brother" and then he will do what?

[The information follows:]

The overall role of the Assistant Secretary for Health is to develop a coordinated national health program. Health strategies must be developed that are responsive to the changing Federal role and to the health needs of the Nation. The Office of the Assistant Secretary for Health is also the focal point for dealing with other Federal agencies, providing the technical and administrative support and policy guidance for health programs administered through the regional offices, evaluating the ongoing health programs to meet the changing needs of our population, carrying out the responsibility as the line manager for the six health agencies, and serving as the staff adviser to the Secretary on all health matters. In addition, many of the functions previously performed by the agencies are now performed by this office such as, establishing policies in grants and contracts management, personnel, management, budget formulation, and planning development.

With regard to the role of the regional offices, the 250 positions listed under the Office of Regional Operations in the Office of the Assistant Secretary for Health, are physically located in the regions. The overall role of the staffs in the regional offices is to bring Government closer to the people that it actually serves, and to simplify the award of grants and contracts, facilitate interagency coordination of program activities, and provide the day-to-day administration of programs while at the same time maintaining an ongoing relationship with States and local health officials, communities, and health care providers.

Mr. FLOOD. Mr. Patten.

SOCIAL SECURITY AMENDMENTS

Mr. PATTEN. I haven't any questions. I do not want to go over the ground that we debated when we amended the Social Security Act.

But you have a responsibility under which we may end up with so much quality, nobody will get any service.

I remember around 1931, after we passed the older citizens welfare bill under the Federal Government, which helped people over 65 or over 70 years of age, we solicited a lot of our friends to open up a little nursing home. Usually it was some large house and took in 12 or 15 people and served the purpose very nicely. But someplace there was a fire, and the State legislature made a rule then it had to be fireproof, had to be brick and steel. Now instead of talking about some widow using a house to take old people in that were unable to stay home, what we called a nursing home, you need $1 million for a little facility with all of the improvements.

We had a lot of women used to help their neighbors, come in the house, and generally we called them nurses' aides. They had no diploma; they didn't pass a State examination.

My recollection is we had a lot of women that would come in for $5 a day and was a big help to the family, but then we legislated that out of business because we didn't get quality.

The net effect of quality was a nursing home service up to like $200 a week in my area. $175 a week. If you want to put Pop in a nursing home, you have to be wealthy. Other people are not allowed because they violate the laws.

When we passed a bill that nurses' aides had to be licensed and pass an examination, we just kept a lot of wonderful women out of the market, because at their age and background, they weren't going to take a State examination. They helped the family and did the laundry and washed the patient and other things the nurse's aide would do, and they would be illegal.

I am a little afraid in establishing these regional offices to insure quality, we are going to have the difference between an old Model T Ford—I had a lot of fun with it, but it didn't cost $1,400. But with all the power steering and automatic brakes and television and air-conditioning and climatic heat control, it costs me $12,000 to buy a car. I think I had more fun with the old Model T that had no windows or anything. You just put on an extra sweater in the wintertime.

I know a lot of people did a wonderful job in the thirties helping others when they needed care, and I am not so sure all of the improvements were good.

We tore ourselves apart in my area and ended up in court trying to pick our organization for the regional review. It was quite a donnybrook, and it lasted quite a while.

I am wondering what the next step is going to be on quality control, whether we are going to end up with a Cadillac and not be able to use the Model T which is within reach. Your work is cut out for you.

I don't know if you heard me say I was in the State legislature for 8 years in the fifties, but my county grew from 100,000 to 600,000 in the postwar period, but we still had the same number of undertakers. The undertakers by controlling the State board made sure that there was not another undertaker licensed unless somebody dies.

I pleaded with our State nursing board to allow a nurse who had worked 10 years in the hospital with very good service, and at that time you didn't need a State examination, and after her husband died, she wanted to go back and probably be a school nurse, and they told me she wouldn't be qualified because she wasn't a high school graduate.

I find these things tend to narrow the market.

Around my way when it comes to medical help, I can't find a general practitioner. Everybody wants $50. They are heart specialists or gland specialists. They are not even eye doctors or dentists any more; they are ophthalmologist or orthodontists. I don't know where we are going.

It seems to me many of these things are wonderful in quality, and the only thing we have done is restrict the availability of some services at a reasonable cost to a large number of people.

So I hope in your quality control and desire to deliver quality medical care, as you review your nursing homes—you said there are probably 12,000. I think you said about 6,500 will meet the minimum requirements for skilled nursing. I can remember when there were 12 people in Mrs. Madden's home out in Avenel, and the nurse didn't hesitate to bring a glass of milk or feed a patient once in a while.

Under our new rules that nurse is not allowed to feed the patient. She just must do nursing. So this put a problem for Mrs. Madden with her 12 old-timers, added to the payroll.

I can tell you the women I know are out of business because of fire laws because of quality control or other big improvements. It just strikes me we have eliminated a lot of wonderful people who gave a lot of service at cost within reach of many a family.

I am interested to see what these regional groups are going to do. I have a feeling that the PSRO's, loaded with professional talent, will be upgraded professional standards and that will mean higher prices and limited service, and the general public won't be as well off as they were before. Anyone who gets the service will be riding in a Cadillac and have no model T Ford.

I hope you proceed modestly. We don't have to chew it all at one time. Do it gradually. Don't close up 500 nursing homes. Be a little lenient and don't listen to all of those professional criers. Think of the public, be a consumer's man when you set these standards.

I can given you specifics. I know a Negro minister who had two nursing homes and after a big fire somewheres the State came in and they were closed up. But the poor souls in his wooden frame buildings were not wanted in other places, and when the sign went up $125 a week they were eliminated and no longer in the system and they didn't get any care.

I hope at the Federal level here we are not all big leaguers. Keep these little nursing homes in business and keep a lot of wonderful people giving medical care and don't let them kick you around for that specialist and supreme service and everything else.

I don't agree with all of this reform. I am shaky about this thing of your having Federal quality standards on the grounds that the people you meet idealistically and correctly would love to see a better service.

Do I make a fair statement based on your own knowledge that as a result of the new fire laws requiring all brick and steel a lot of people are out of the nursing home business who hardly made a living out of it? They are eliminated. A lot of wonderful women went in and cooked the meal for the old man and wash the dishes and take care of a patient and delivered a baby and all. In my State today it is illegal. If you get a nurse for a patient you end up with a bill for $70 a day at top professional rates. Nurse's aides are very limited. It is hard to find them. I know a little something about the neighborly list I saw that was of good quality.

A number of things change. I am not always for reform. I hope in your role you don't get so high class only the fellow who can buy a Cadillac are going into the nursing home and get some of these medical services.

Do I make my point?

Dr. SIMMONS. Certainly, Mr. Patten. It is hard to disagree that you always have to be careful in improving things, or else it doesn't work. The sad thing is that in some of the terrible nursing home tragedies we have had, the improvement wouldn't be very expensive. A smoke door costs $700, and 12 or 13 people wouldn't have burned to death. All of the important improvements aren't necessarily expensive, but they have to make some sense. You have to be careful. Improvement may hurt more people than it helps.

Mr. PATTEN. I have no more questions.

DECENTRALIZED HEALTH PROGRAMS

Mr. CONTE. For decentralized health programs, it is hard to see how responsibility is going to be divided between regional offices and the agencies to which appropriations are made. Will you describe the relationship both as to policy and actual program management?

Dr. SIMMONS. Many health programs have been decentralized for quite a number of years, in which the fundamental responsibility of the central office has been the development and evaluation of national policies and priorities with the regional offices responsible for program implementation. Recent efforts under the Department policy of decentralization have been directed to defining further these responsibilities through a careful analysis of specific program functions and determining the proper location of responsibility between headquarters and the regional offices. In relation to total Federal health programs, we also recognized the need to clearly establish a capability to provide overall PHS direction, management, and coordination of an increasing variety of health programs from the several health agencies that are carried out in the region. For this reason, with the PHS reorganization, we strengthened the role of the Regional Health Administrator as the principle health official in the region, reporting directly to the Assistant Secretary for Health with authority to direct and control PHS regional components and resources.

Extensive interaction between headquarters and regional offices is necessary in order that each can effectively implement their relevant responsibilities. The regional offices must provide input to the central offices for policy and program development, based on their experience in program implementation and greater awareness of local situations. By the same token, the central office agencies must provide clear guidance to the regions on national policies, regulations and priorities as well as the resources that will be made available to the regions for implementation of specific program expectations.

We are engaged in many activities to facilitate more effective working relationships between the regions and central offices. The Office of Regional Operations was established as a staff office to the Assistant Secretary for Health to assist him in all matters pertaining to the operations of the PHS regional offices. This office is working intensively with the agencies and the regions in the development of a new system called the Regional Health Administrator's work program. This system will provide a vehicle for: The agencies to provide timely and consistent guidance to the RHA's on all national policies and programs for regional implementation; the RHA's to plan the coordinated use of all PHS programs in the regions; and monitoring and feedback on program accomplishments and identification and resolution of specific issues. In addition to this formal process for improving interaction between central and regional offices on major decisions regarding policy directions and resource allocations, the more informal line of communication between central and regional program counterparts will be continued to assure the necessary exchange of programmatic and technical information that is vital to each in the implemention of their related responsibilities.

Mr. CONTE. Are all regional office staff responsible to the Office of the Assistant Secretary or only the "core" staff? If the latter, what are the problems of having regional office staff reporting to agencies, while the heads of the regional offices report to the Office of the Assistant Secretary?

Dr. SIMMONS. Health staff located in the regional office are responsible to the Regional Health Administrator, who in turn is responsible to the Assistant Secretary for Health. Positions are budgeted in several appropriations which support the many decentralized health programs.

In this regard, the "core" staff is budgeted in "Salaries and expenses" for the Office of the Assistant Secretary for Health since these staff support overall regional office operations including programs now funded by several of the health agencies. Authority for the implementation of decentralized health programs is delegated from the Assistant Secretary for Health to the Regional Health Administrator, including full responsibility for the total regional office health staff required for program operations in the regions. This authority and responsibility to direct the overall management of PHS regional office activities was clearly established in the recent PHS reorganization. This classification of roles is intended to provide the most effective management of resources and a more responsive administration of health activities of the population served by the region. I might mention that there is one exception for the management of FDA field activities. All authority for the implementation of FDA programs is delegated from the Assistant Secretary to the Commission of the FDA. This is because of the unique nature of these programs in the enforcement of laws, requiring immediate and direct access of the central office to the nationwide network of the FDA.

AVERAGE SUPPORT FOR PSRO

Mr. CONTE. What will be the average support for a PSRO and for a State PSR Council?

Dr. SIMMONS. Experience with prototype PSRO planning has been limited to date. The experience of the existing medical care review organizations, coupled with the PSRO legislative requirements, indicate that it shall cost approximately $50,000 to support the design of a formal plan for assuming the duties and functioning of a PSRO.

Actual prototype PSRO experience is relatively limited to date. A few medical care review organizations are now in operation, but none are operating as the legislated PSRO's will operate. However, these organizations, when coupled with the PSRO legislation, do provide some "benchmarks" against which to estimate average costs of PSRO's.

The average budget for the first conditional year will vary considerably from as low as $100,000 to as high as $500,000, with an average cost of about $300,000. The lower funding levels will relate to those organizations in their early development stages, with funding progressively increasing coincident with the initiation of review.

With the limited experience to date it is estimated that the average cost of a State PSR Council will average about $200,000.

EVALUATION OF PSRO

Mr. CONTE. How much are you budgeting for evaluation of PSRO performance and what plans do you have for evaluation programs?

Dr. SIMMONS. The strategy for the evaluation of the PSRO program is now being developed by our staff. Until this strategy is completed it would be difficult to furnish you with a realistic estimate of its cost. We will furnish you with the plans for the evaluation program, as well as our best estimate of its cost, as soon as they are developed.

TECHNICAL ASSISTANCE TO PSRO'S

Mr. CONTE. What resources do you have for providing technical assistance to PSRO's? Isn't this such a new kind of enterprise that we have little experience or expertise to draw on?

Dr. SIMMONS. Technical assistance will be provide to the PSRO's from a number of different sources. DHEW realizes that a strong program of technical assistance is vital to the success of the PSRO program. We plan to have technical assistance for PSRO's from a number of sources.

The PSRO's will be assisted by both central and regional office personnel from DHEW. A number of extensive training sessions have been conducted to orient regional office staffs in the operations of the PSRO program. In addition, one person in each of the 10 DHEW regional offices has been identified as the focal point for all PSRO activity. That person will be responsible for coordinating PSRO activity, assisting the PSRO's in the region, and acting as liaison between the PSRO and DHEW central office.

Statewide support centers will be established under contract to stimulate and support the development and operation of the PSRO program and the local PSRO's in a manner consistent with the legislative intent and the policies of the Secretary. Support centers could thus provide professional, administrative and technical support to assist local PSRO's in carrying out their standard setting and peer review responsibilities. Contracts with support centers would be let on a competitive basis and the tasks to be performed under all contracts and subcontracts would be subject to our approval. We will also let contracts to develop models that the local PSRO's may modify and use as appropriate to their particular situation. These models include criteria, accounting systems, review systems, data systems, et cetera. These models should greatly reduce the duplication of expense and effort for the local PSRO's.

To supplement these contracts and our own staff we will identify appropriate consultants that have demonstrated particular expertise in subjects related to PSRO activities. These consultants will work with us and the local PSRO's to see that the PSRO activities are carried out in the most effective and efficient manner possible.

We also plan to fund a number of contracts to train persons involved in PSRO activities. These training programs will include both physicians and administrative personnel. Such training is necessary that the PSRO's are operated in an effective, efficient and somewhat uniform fashion.

The PSRO program is a major new initiative, but while the available expertise and experience is limited, it does exist. We have attempted to draw from the experience of the federally funded Experimental Medical Care Review Organizations (EMCRO's), and of other medical care foundations and organizations involved in peer review. We have also drawn from the expertise available within the medical community.

ASSESSMENT OF COMPREHENSIVE HEALTH PLANNING EFFORT

Mr. CONTE. The justification mentions an assessment of comprehensive health planning efforts in 1974. Is that available? Will you summarize the major findings? Did that assessment feed into planning the administration's new health planning legislation?

Dr. SIMMONS. The site assessments of the 56 State comprehensive health planning agencies and 162 areawide comprehensive health planning agencies in the planning phase have not yet been completed. As of April 1, 1974, 25 State agencies and 127 areawide agencies were assessed. A final analysis of findings on all agencies assessed by June 30, 1974 will be submitted to the Secretary by the end of this summer.

The assessments did not feed into the administration's proposal on health resources planning. The overall goal of the site assessment is to determine an agency's status in terms of a series of performance standards which were developed for State and areawide comprehensive health planning agencies.

COOLEY'S ANEMIA

Mr. CONTE. On page 196 several areas are listed in which the Office is coordinating health agencies' efforts. The one area not even mentioned is Cooley's anemia, despite specific legislation. For the record, will you provide a detailed description of present efforts in that area and of the Office's role in coordinating them and developing new efforts?

Dr. SIMMONS. Cooley's anemia legislation concerns: (1) Research; (2) screening, treatment, and counseling; and (3) development and dissemination of information and educational materials. Responsibility for implementation of the research portion was assigned to the National Institutes of Health (NIH). NIH research, apart from basic studies in blood diseases, is concerned with an immediate need for further clinical investigation directed toward better therapy, especially in reference to development of a new iron chelator and transfusion therapy.

NIH has assumed responsibility for administration and funding to develop an effective and inexpensive small scale pilot program to screen for thalassemia trait and counseling of those with the condition. The specifications of the work to be performed under the contract are being developed. It is expected that it will be possible to award a contract to begin work early in fiscal year 1975, and that a period of approximately 2 years will be required for the first phase to be completed. From this effort, the major question to be answered is whether a mass screening program of the kind should be considered for the Nation. These will be problems of mutual interest to NIH and Health Services Administration (HSA). The responsibility for the development and dissemination of information and educational materials is with HSA.

The Office of the Assistant Secretary for Health is presently coordinating Cooley's anemia activities, which are being carried out by NIH, and those in the process of being developed by HSA. The staff not only monitors the research and delivery components of this program, but also makes certain that the knowledge acquired through research of the sickle cell anemia program, and from other similarly related diseases are properly utilized in this effort.

TRAINING PROGRAMS FOR NURSING HOME EMPLOYEES

Mr. CONTE. Why are training programs for nursing home employees being run out of the Assistant Secretary's office instead of one of the agencies?

Dr. SIMMONS. The Office of Nursing Home Affairs, Office of the Assistant Secretary for Health, provides overall guidance and coordinates efforts of all of the activities related to the President's 1971 initiatives for nursing home improvement which are being implemented in the PHS agencies and regional offices. Specifically, the Health Resources Administration, is responsible for an annual budget of $1.8 million which is all directed toward training provider personnel of nursing homes. Another $300,000 is managed by the Alcohol, Drug Abuse, and Mental Health Administration, which focuses primarily on the psychosocial aspects of the care provided by nursing home personnel. The Office of the Under Secretary has recently proposed the organization of divisions of long term care in the Office of the Regional Directors. Responsibility for stimulating training opportunities to meet special needs of nursing home employees in each region would be delegated to that unit.

PUBLIC AFFAIRS ACTIVITIES

Mr. CONTE. How much of the requested budget for program direction and support services will be spent on public affairs?

Dr. SIMMONS. Of the $14,146,000 requested for program direction and support services, $301,000 is required to support the 10 positions associated with the public affairs functions.

INTERNATIONAL HEALTH EFFORTS

Mr. CONTE. What are some specific international health efforts you plan for 1975?

Dr. SIMMONS. International health efforts planned for 1975 will, as in the past, be aimed at complementing the domestic mission of this Department. It is also intended that DHEW will intensify its activities involving coordination of the input of U.S. Government agencies such as State (including the Agency for International Development), Commerce, Agriculture, the Environmental Protection Agency, et cetera, into the entire international health field.

We anticipate an increase in our bilateral collaborative activities with such countries as the Arab Republic of Egypt, India, Japan, Mexico, Pakistan, Poland, and the Soviet Union. In some of these countries, research conducted by local scientists will be financed by U.S.-owned excess currencies (PL 480 funds). In other countries, cooperative research programs are being carried out through joint agreements between DHEW and local Ministries of Health. A limited number of specific examples include: cancer, heart disease, environmental health and arthritis with the Soviet Union; occupational health, rehabilitation, neurological and psychiatric disorders, food and drug health problems, infectious diseases and health services delivery with Poland; research into nutrition in India; research into hepatitis in the Arab Republic of Egypt and food and drug activities with Japan.

In response to requests from the Agency for International Development, we are providing technical assistance to several countries in the development of their health planning and health sector analysis. Information and experience gained through this process provides a valuable feedback to the domestic health activities of the Department.

The Office of the Assistant Secretary for Health is responsible for developing U.S. input into the activities of the World Health Organization (WHO), and, hence, provides analyses and evaluation of the programs conducted by that Organization. This process, aided by the input of the Department of State, helps to ascertain that U.S. contributions to the World Health Organization are effectively utilized, as well as assisting the Organization to be responsive to health needs worldwide.

Mr. FLOOD. Thank you, gentlemen. Good luck. You are going to need it.

JUSTIFICATION OF THE BUDGET ESTIMATES

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Amounts Available for Obligation 1/

	1974 Revised	1975
Appropriation	$12,000,000	$52,299,000
Proposed supplemental for pay costs	945,000	
Subtotal, adjusted appropriation	12,945,000	52,299,000
Comparative transfers to:		
"Food and Drug Administration" Transfer of administrative support for Commissioned Officer Personnel function.	-41,000	
"Health Services Transfer of administrative support for Equal Employment Opportunity, Legislation, Administrative Management, Personnel Management, Procurement, Fiscal services, and Commissioned Officer Personnel functions.	-4,100,000	
"Indian Health" Transfer of administrative support for Commissioned Officer Personnel function.	-205,000	
"Preventive Health Services Transfer of administrative support for Commissioned Officer Personnel function.	-73,000	
"Office of the Director, NIH" Transfer of administrative support for Commissioned Officer Personnel function.	-155,000	
"Alcohol, Drug Abuse, and Mental Health" Transfer of administrative support for Commissioned Officer Personnel and Employee Health Program on Alcoholism functions.	-42,000	
"Health Resources" Transfer of administrative support for Equal Employment Opportunity, Upward Mobility, Committee Management, and Commissioned Officer Personnel functions.	-2,013,000	

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Amounts Available for Obligation 1/

Comparative transfers from:	1974 Revised	1975
"Food and Drug Administration....... Transfer of administrative support for Administrative Management, Program operations, Equal Employment Opportunity, Policy Development and Plannig, and Executive direction functions.	626,000	
"Health Services".................. Transfer of administrative support for Regional Office Central Staff, Policy Development and Planning, Population Affairs, and Regional operation functions.	6,447,000	
"Preventive Health Services"........ Transfer of administrative support for Administrative Management, Regional operations, and International Health functions.	108,000	
"National Cancer Institute".........	193,000	
"National Heart and Lung Institute..	77,000	
"National Institute of Dental Research"........................	31,000	
"National Institute of Arthritis, Metabolism, and Digestive Diseases"........................	63,000	
"National Institute of Neurological Diseases and Stroke"......	63,000	
"National Institute of Allergy and Infectious Diseases".............	60,000	
"National Institute of General Medical Sciences".................	44,000	
"National Institute of Child Health and Human Development.............	73,000	
"National Institute of Environmental Health Sciences"...........	30,000	
"National Library of Medicine"......	66,000	
"Office of the Director, NIH"....... Transfer of administrative support for Administrative Management, Policy Development and Planning, and Program operations functions.	83,000	
"Alcohol, Drug Abuse, and Mental Health"........................ Transfer of administrative support for Administrative Management, and Regional operation functions.	413,000	

Amounts Available for Obligation 1/

	1974 Revised	1975
"Health Resources".................. Transfer of administrative support for Equal Employment Opportunity and Regional operations functions.	289,000	
"Departmental Management............ Transfer of administrative support for Executive Secretariat, Program operation, Policy Development and Planning, PSRO activity, Executive direction, Population Affairs, Personnel Management, International Health, and Nursing Home Affairs functions.	5,211,000	
"Social and Rehabilitation Service"..	16,075,000	
Subtotal, budget authority.......	36,268,000	52,299,000
Receipts and reimbursements from:		
"Trust Funds"........................	16,775,000	27,000,000
Total, obligations..................	53,043,000	79,299,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1974 - $231,000; 1975 - $231,000.

Summary of Changes

1974 Estimated obligations	$53,043,000
1975 Estimated obligations	79,299,000
Net change	+26,256,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Within grade increases	---	---	---	+$330,000
2. Annualization of new 1974 positions	---	---	---	+1,448,000
3. One extra day of pay	---	---	---	+55,000
4. DHEW Working Capital Fund costs	---	---	---	+29,000
5. PHS Service and Supply Fund costs	---	---	---	+56,000
6. Annualization of October 1973, pay costs	---	---	---	+334,000
7. Service, Lease, and Users Charge	---	---	---	+1,201,000
8. Increase in the telephone rates	---	---	---	+38,000
Subtotal	---	---	---	+3,491,000
B. Program:				
1. Professional Standards Review Organizations	141	$33,670,000	+175	+22,765,000
Total, net change	---	---	+175	+26,256,000

Obligations by Activity

Page Ref.		1974 Base		1975 Estimate		Increase of Decrease		
		Pos.	Amount	Pos.	Amount	Pos.	Amount	
193	Regional office central staff...............	250	$5,909,000	250	$7,253,000	---	+$1,344,000	A/
195	Program direction and support services....	507	13,464,000	507	14,146,000	---	+682,000	B/
198	Professional standards review organizations.......	141	33,670,000	316	57,900,000	+175	+24,230,000	C/
	Total obligations....	898	53,043,000	1,073	79,299,000	+175	+26,256,000	

Explanation of Changes (by activity)

A) The total increase of $1,344,000 for this activity is for mandatory items.

B) The total increase of $682,000 for this activity is for mandatory items.

C) A total increase of $24,230,000 is requested for this activity. Of this amount $1,465,000 will cover mandatory items, $19,865,000 will support about 70 new Professional Standards Review Organizations (PSRO's) and 12 Professional Standards Review State councils and support contracts, and $2,900,000 will support 175 new positions for the expanded PSRO program.

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Total number of permanent positions......................	898	1,073	+175
Full-time equivalent of all other positions................	58	63	+5
Average number of all employees......................	900	1,072	+172
Personnel compensation:			
Permanent positions...........	$15,755,000	$19,578,000	+$3,823,000
Positions other than permanent....................	379,000	474,000	+95,000
Other personnel compensation...	142,000	159,000	+17,000
Subtotal, personnel compensation..............	16,276,000	20,211,000	+3,935,000
Personnel benefits.............	1,625,000	1,957,000	+332,000
Travel and transportation of persons.......................	1,075,000	1,337,000	+262,000
Transportations of things.......	62,000	77,000	+15,000
Rent, communications and utilities....................	706,000	2,030,000	+1,324,000
Printing and reproduction.......	170,000	188,000	+18,000
Other services.................	1,215,000	1,508,000	+293,000
Project contracts.............	31,675,000	51,540,000	+19,865,000
Supplies and materials.........	110,000	146,000	+36,000
Equipment......................	129,000	305,000	+176,000
Total obligations by object...	53,043,000	79,299,000	+26,256,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be taken
1974 Senate Report **Office of the Administrator**	
The Senate was concerned that too many positions were transferred to this account for the support of the Assistant Secretary for Health. Therefore, the Senate allowance reduced the request and House allowance of $14,304,000 to $12,000,000.	The reduction of $2,304,000 in the Health Services and Mental Health, Office of Administration appropriation was achieved by eliminating $495,000 of program increases originally included in the budget estimates and discontinuing the funding of 49 positions and $1,809,000 for the following activities: tort claims processing, the Parklawn library, fiscal, procurement and supply services. These activities are not staff functions for the Assistant Secretary for Health. The cost of these activities will be financed through the PHS Service and Supply Fund and billed to those programs being served by these activities.

Authorizing Legislation

Legislation	1975 Authorized	1975 Appropriation requested
Social Security Act		
Title XI, Part B -- General Provisions and Professional Standards Review	Indefinite	$30,900,000

Office of the Assistant Secretary for Health,
Salaries and Expenses

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1965...	$6,214,000	$6,214,000	$6,214,000	$6,214,000
1966...	6,648,000	6,648,000	6,648,000	6,648,000
1967...	8,207,000	8,069,000	7,648,000	7,858,000
1968...	9,087,000	8,358,000	8,358,000	8,358,000
1969...	9,073,000	9,073,000	9,073,000	9,073,000
1970...	9,898,000	9,898,000	9,898,000	9,898,000
1971...	12,636,000	12,636,000	12,636,000	12,636,000
1972...	12,497,000	12,497,000	12,497,000	12,497,000
1973...	20,519,000	20,519,000	20,519,000	20,519,000
1974...	37,627,000	37,627,000	30,323,000	35,323,000
Supplemental.	945,000			
1975...	52,299,000			

Office of the Assistant Secretary for Health

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.......	898	$17,901,000	1,073	$22,168,000	+175	+$4,267,000
Other expenses...	---	35,142,000	---	57,131,000		+21,989,000
Total........	898	53,043,000	1,073	79,299,000	+175	+26,256,000
Activities						
1. Regional Office Central Staff......	250	5,909,000	250	7,253,000	---	+1,344,000
2. Program Direction and Support Services...	507	13,464,000	507	14,146,000	---	+682,000
3. Professional Standards Review Organizations......	141	33,670,000	316	57,900,000	+175	+24,230,000
Total........	898	53,043,000	1,073	79,299,000	+175	+26,256,000

General Statement

This appropriation provides support for the administrative staff of the ten Regional Health Administrators, staff for the Assistant Secretary for Health, and resources necessary for the maintenance of the nationwide professional standards review organization activities. The Assistant Secretary for Health is the principal advisor to the Secretary on health policy and all health-related activities for the Department, and is responsible for the direction of the Public Health Service health agencies. He provides leadership and policy guidance for health-related activities for the people of the Nation, and for maintaining relationships with other governmental, private agencies, and some international health organizations concerned with health and health-related matters.

Regional Office Central Staff

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..	250	$4,948,000	250	$5,091,000	---	+$143,000
Other expenses.......	---	961,000	---	2,162,000	---	+1,201,000
Total...........	250	5,909,000	250	7,253,000	---	+1,344,000

The staff supported by this activity is located in the ten regional offices. This activity supports the immediate office of the Regional Health Administrators, the principal health officials in the regions, who are responsible to the Assistant Secretary for Health. The Regional Health Administrators determine regional health policies, set priorities, goals and objectives for the regions within the scope of national health policies. They administer more than 40 decentralized health programs and activities funded by appropriations of four of the six PHS health agencies. Technical assistance and consultations to State, local and community organizations to improve the delivery of health services is also provided through the Regional Offices.

In 1974, the Regional Office Central Staff continued to provide the overall management capabilities necessary to administer the decentralized health program in the ten Regional Offices. Further decentralization of health programs during 1974, including major health manpower activities, has placed greater responsibility on the central staff. Currently there are some 6,000 grants totalling $1.4 billion being awarded and administered in the regional offices. In 1974, the special responsibility of the central staff to administer the Comprehensive Health Planning Program included an intensive effort to assess the performance of all area-wide Community Health Planning Agencies and to provide direction and assistance to improve their operations where necessary. The central staff also participated in establishing the Professional Standards Review Organizations. A major undertaking in 1974 was the participation of the central staff in the reorganization of regional health activities. This reorganization will give the Regional Health Administrators the structure needed to support their expanded role as principal health officials in the regions and provide for more effective direction, management and coordination of decentralized health programs. Emphasis will continue to be placed on improving coordination with State and local health agencies, development and implementation of regional plans for achieving national health priorities and strategies, and working with the HEW Regional Directors in coordinating all HEW programs in the regions.

The primary focus of the Regional Office Central Staff in 1975 will be to make management and administrative improvements which will enhance the regional office capability to effectively implement their responsibilities as the operational arm of the Public Health Service with regard to decentralized programs. This will include continuing activities in effectively implementing the reorganization initiated in 1974. In addition, new procedures in operational planning and resource management will be implemented which will place major new responsibilities on the central staff. This overall system, known as the Regional Health Administrators Work Program, will provide a structured process by which: (1) the regional offices will receive earlier and clearer guidance on goals, resources and expectations consistent with national program objectives;

(2) they will have the opportunity to meld these series of programmatic objectives into an overall regional health response which considers the particular health needs of the regions; and (3) there will be consistent monitoring of activities to assure implementation of objectives as well as necessary redirection of efforts responsive to changing situations. This will be done in close coordination with the health agency's headquarters personnel to assure accomplishment of categorical program objectives within the context of an integrated health strategy in the regions.

An increase of $1,344,000 is required to provide for mandatory costs for within grade increases effective during the year, $63,000; annualization of the October 1973 pay raise, $66,000; one extra day of pay, $14,000; and $1,201,000 to be transferred to the General Services Administration for space rental charges.

Program Direction and Support Services

	1974		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.......	507	$11,162,000	507	$11,721,000	---	+$559,000
Other expenses.......	---	2,302,000	---	2,425,000	---	+123,000
Total...........	507	13,464,000	507	14,146,000	---	+682,000

This activity supports the Office of the Assistant Secretary for Health. It provides staff support for the Assistant Secretary for guidance, leadership and direction to the Public Health Service Agencies on all health and health-related activities, including research and development; education and training; organization financing and delivery of health care services; provision of preventive health services; and protection to the public from unsafe foods, drugs, and medical devices.

In 1974 the Administration effected a reorganization of health activities in the Department to more effectively meet the health needs of the Nation. The effectiveness of the reorganization requires a well balanced management staff for the Office of the Assistant Secretary for Health (OASH). To provide this staff, positions were transferred into the OASH as follows: 254 from the Office of the Administrator appropriation of the former Health Service and Mental Health Administration, 142 positions from the Departmental Management appropriation which had been serving the Assistant Secretary for health, and 111 from various health programs within the Public Health Service.

This activity includes staff and related costs for the Immediate Office of the Assistant Secretary for Health, Equal Employment Opportunity, Executive Secretariat, Public Affairs, International Health, Population Affairs, Nursing Home Affairs, Administrative Management, Policy Development and Planning, Program Operations, and Regional Operations. Some of the achievements and goals for fiscal years 1974 and 1975 for OASH are:

The financial management operations, centered on the development of uniform financial management policies, procedures, accounting techniques and reporting systems for the health agencies, including regional offices. Uniform grant, procurement and material policies were written and the operational planning systems of the independent health agencies were integrated. The Commissioned Corps personnel management activities were integrated and coordinated with those associated with the administration and management of personnel covered by Civil Service authority. Initiatives started in 1974 will be continued in 1975. Also, greater participation of regional office staff will be promoted by directly involving the regions in the budget preparation process. Procurement review procedures will be expanded to prevent unnecessary duplication among health agencies. The health facilities long-range plans will be revised and a new annual plan will be prepared. Optimum staffing standards for the Public Health Service (PHS) will be initiated and the recruitment of health professionals for the six PHS Health agencies will be strengthened and expanded.

The Forward Plan for Health was prepared and plans for program evaluation and health services research were implemented. Increased participation in the development of major areas of national health policy concerning a national Health Insurance Plan, health manpower policies, and improved health resources planning was achieved in 1974. In 1975 guidelines and plans for health programs and their evaluation will continue to be developed. Sound policies relating to the collection and analysis of health data will be developed and other health policy matters will be addressed as they arise, as well as to review, on a continuing basis, current policies relating to Federal health programs and the Nation's health systems. Particular emphasis will be placed upon such issues as the potential impact of changes in health care financing, including the impact of federally supported services, and the impact of State and local fiscal and regulatory roles upon the demand for and supply of health manpower and services.

A process for work plan program development was implemented during 1974 to assist the Regional Health Administrators in carrying out the decentralized activities for which they have been given responsibility and authority to implement. As part of this process, extensive training has been conducted for the headquarters and PHS regional office staffs managing the regional offices activities by objectives and work program planning. The PHS regional offices were assisted in the development and implementation of the 1974 decentralized efforts. Improved communication has been emphasized and accomplished through regular meetings of the Regional Health Administrators and headquarters staff which have included agency and program participation.

Efforts begun in 1974 to provide advice and guidance to the PHS regional offices will be continued in 1975 in the area of work program planning and management by objectives to insure that national goals, objectives and priorities of the various Public Health Service Agencies are met and accountability is achieved. An evaluation of these efforts will be undertaken and will be supplemented by quarterly reviews of PHS regional office objectives established by their work plans. Assistance will be provided in finalizing reorganization efforts by providing management assistance in the areas of personnel, budget, planning, evaluation and program development. Also, action will be initiated to develop training opportunities to assist PHS regional offices in upgrading existing staffs in area of management, program development, program implementation, planning and evaluation.

Program Operations functions were initiated in July 1973 to serve as the focal point for advising the Assistant Secretary on operating problems, monitoring the implementation of program policies and objectives and coordinating legislative and freedom of information activities. A system to facilitate program coordination to bring about more effective research, development, and health care delivery among the PHS agencies was instituted. The staff is jointly participating with the PHS agencies to assure coordination in cross-agency programs in the research and service activities of satellite and other telecommunications, aging, child abuse, toxicology, nutrition, hypertension, sickle cell disease, cancer, the development of a modified research fellowship training program supported by several PHS agencies, and the development of a uniform Federal policy with respect to human experimentation. Efforts are also underway to improve communications and collaborative studies with the Environmental Protection Agency, the National Aeronautics and Space Administration, the Veterans Administration, and the Federal Energy Office concerning health-related programs. These functions will continue in 1975 to aid in the implementation of new program policies and new legislative with particular concentration on programs with multiple PHS agency participation as well as with participation of other Federal agencies and non-Federal organizations such as the operational aspects of the end stage renal disease program, the emergency medical services activities, the operation of the PHS hospitals, and the coordination of the health efforts of the PHS in relation to the energy situation. Additional emphasis will be placed on providing health liaison services and expanded coordination of representation and participation of the Office of the Assistant Secretary at appropriate meetings with other elements of the Department, other Federal agencies, professional and allied health groups, special interest groups, and with major health organizations.

Training programs geared to ensure better performance and capabilities on the part of nursing home employees have been developed. The number of nursing home employees receiving short-term training was 23,000 in 1973 and is anticipated to be 40,000 by the end of fiscal year 1974. In 1975 initiatives to coordinate, consolidate, implement, and enforce standards for skilled nursing facilities under titles XVIII and XIX of the Social Security Act and for intermediate care facilities will be continued. By the end of 1975 it is estimated that between 6,500 and 7,000 skilled nursing facilities and 4,500 to 5,000 intermediate care facilities will have met minimum Federal standards. Training of nursing home personnel will also be continued in 1975.

During 1974 the Department's annual reports on "Population and Family Planning Activities" and the "Five Year Plan for Family Planning Services and Population Research Programs" were prepared as required by PL 92-572. Some 4,000,000 women received subsidized services through organized programs and many more received services from private physicians. An active role in formulating the Department's regulations concerning sterilization and family planning services provided Aid to Families with Dependent Children. Family planning services and population research activities will be continued as a high priority in 1975.

During FY 1974 technical assistance on international health matters was rendered to the Department of State, the Agency for International Development, the World Health Organization, the Pan American Health Organization, numerous international health and health-related organizations, Ministries of Health of many countries and domestic organizations and individuals seeking advice on international health matters. Participation in policy decisions and other preparations for the meetings of the World Health Organization's governing bodies and membership in the U.S. delegations to them permitted the promotion of significant initiatives in several areas of international health collaboration such as biomedical research, cancer and drug abuse. Another major accomplishment has been the ability to make greater input into the U.S. Government's involvement with the World Health Organization and other international health bodies through careful analysis of the impact of their programs. Plans for 1975 involve principally a continuing contribution to improving the participation of the U.S. Government in international health activities. This will be through our efforts to strengthen existing bilateral programs and our involvement with the World Health Organization and other international health organizations.

In summary, a total of $14,146,000 is requested for the continuation of this activity. The net increase of $682,000 over the 1974 operating level of $13,464,000 represents mandatory costs such as, within grade increases, annualization of positions new in 1974, one extra day of pay, increase in telephone rates, annualization of 1974 pay raises, and increased costs for DHEW Working Capital Fund and PHS Service and Supply Fund.

Professional Standards Review Organization

	1974 Base		1975		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	141	$1,791,000	316	$5,356,000	+175	+$3,565,000
Other expenses........	---	31,879,000	---	52,544,000	---	+20,665,000
Total............	141	33,670,000	316	57,900,000	+175	+24,230,000

The Professional Standards Review Organization (PSRO) program was authorized by the 1972 amendments to the Social Security Act. The PSRO provision of Public Law 92-603 (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to regulate the quality of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. The purpose of the statute is twofold: (a) to improve the quality of health care services; and (b) make more cost effective the expenditures for health care services financed by Titles XVIII, XIX, and V of the Social Security Act. PSROs are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

PSROs will be required to assess and assure the appropriateness and quality of care by (a) reviewing health care services prior to, during, and after their provision against agreed upon standards of care acceptable to the profession and consistent with high quality care; and (b) identifying local health care practices that are of less than adequate quality, determining their cause and taking actions to correct them.

Through the application of standards and peer review techniques, PSROs will be responsible for assuring more effective use of the dollars expended for health services by assuring the following:

1. that payments are made only for medically necessary admissions to hospitals and skilled nursing facilities;
2. that payments support only medically necessary continued stays in hospitals and skilled nursing facilities;
3. that payments are made only for services, tests, and procedures that are medically necessary; and
4. that beneficiaries and recipients of Medicare and Medicaid who do require care are indeed receiving services of high quality.

In brief, PSROs must review the medical necessity of services, the quality of care delivered, and the appropriateness of the care in terms of the level, duration, and methods of treatment. In reviewing medical necessity and quality, PSROs will be determining whether health care services provided are necessary on the basis of professionally developed standards of norms of care, diagnosis, and treatment. In reviewing appropriateness, PSROs must determine whether policy formulation, operational planning, and administrative tasks must be completed. Policies will be developed and issued relating to: (a) the conduct of professional standards review by PSROs; (b) the development and application by PSROs of norms, criteria, and professional standards of health care; data requirements; in-house review; (c) the design and application of professional review methodologies for PSROs; (d) the relationship of PSROs to regional offices and PSR State Councils; (e) the PSRO organizational structure; (f) the role of the PSR State Councils; (g) monitoring and comparative evaluation of PSRO performance; (h) physician polling, appeals, sanctions, reimbursement; and (i) Medicare/Medicaid coordination.

(3) Professional Support and Technical Assistance

a. Professional Support: Several key areas require further development. In particular, criteria will be developed for inpatient, long-term and ambulatory care which could be utilized or adapted by the local PSRO. This is a complex task, requiring the expertise of the professional medical specialty societies, geared to local practitioners. Other areas such as review methods and uniform data approaches will also be developed.

b. Technical Assistance: There is no doubt that the developing PSROs will require significant technical assistance if they are to become operational and effective. They will require expert advice and assistance on: criteria development; design of review methods; application of norms in the review process; organizational techniques to meet statutory requirements; data and data analysis; and sanctions and education.

(4) Expansion of the Scope of PSRO Review. Priority activities include the following: 1) development of policies, operational plans, and administrative arrangements for expanding PSRO review activities; 2) initiation of demonstration projects in selected PSROs to expand review activities to encompass long-term care and/or ambulatory practice; 3) further development of PSRO review systems for special settings such as Health Maintenance Organizations and mental hospitals; and 4) continued integration of other review activities such as utilization, medical, and independent professional review with PSRO activities.

All of the PSRO activities initiated in 1974 will continue at an accelerated pace in 1975 except area designation which will have been concluded. We will conclude agreements with an additional 70 PSRO projects and 12 State Councils and continue professional support and technical assistance activities.

In order to carry out and expand the PSRO program, we are requesting an increase of 175 professional and support staff. This will provide a total of 316 positions which is an essential prerequisite to assure effective implementation and monitoring of the program. During the period between now and 1976 when the program is to be fully operational, (i.e., no conditional PSROs), it will be necessary to recruit and train a full complement of central and regional office staff capable of administering the program in a financially responsible manner as to ensure accountability for the funds obligated to PSROs and State Councils.

In summary, a total of $57,900,000 is requested for this program. This represents an increase of $24,230,000 over the 1974 level of operations. The increase is composed of $1,465,000 to cover mandatory items, $2,900,000 for support of 175 new positions and $19,865,000 for 82 new PSRO agreements and State Councils. Since this activity is concerned with the quality of health care services financed by Titles XVIII, XIX, and V of the Social Security Act, the funding for the PSRO program is split between direct appropriated funds ($30,900,000) and reimbursable funds from the Social Security Trust Funds ($27,000,000).

Department of Health, Education and Welfare

Assistant Secretary for Health

Program Purpose and Accomplishments

Activity: Professional standards review organizations (Social Security Act as amended, Title XI, Part B)

1974		1975		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
141	$16,895,000 (33,670,000)	Indefinite	316	$30,900,000 (57,900,000)

Purpose: To assure, through the application of suitable procedures of professional standards review, that the services financed by Titles XVIII, XIX, and [illegible] of the Social Security Act will conform to appropriate professional standards for the provision of health care. To promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made.

Explanation: The PSRO program was authorized by the 1972 amendments to the Social Security Act. This provision of Public Law 92-603 (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to regulate the quality of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. PSRO's objectives are to accomplish this by applying sophisticated concepts of peer review through a system of voluntary local organizations, State Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

Accomplishments in 1974: PSRO activities concentrated on three major objectives:

1. Area designation
2. Initial PSRO program implementation
3. Provision of technical assistance to potential and beginning PSRO's and PSR State Councils

In December 1973, the Secretary tentatively designated 182 PSRO areas throughout the United States. This required a complex series of consultations with interested and affected local and State organizations prior to the designation.

PSRO program implementation activities will focus on the development of basic program policies, procedures, interim regulations, and operating guidelines resulting in the funding of some of the designated PSRO's and PSR State Councils. Before entering into agreements, policies will be developed in such areas as (1) the conduct of professional standards review by PSRO's, (2) the PSRO organizational structure, (3) the roles of State Councils, (4) physician polling procedures, (5) the PSRO application and selection process and (6) other related issues. It is estimated that 50 PSRO's and 6 PSR State Councils will be funded this year.

Technical assistance will be provided through regional offices to potential and newly forming PSRO's and State Councils in the areas of (1) organization, development and administration and (2) professional activities.

the level at which the health care service is provided (e.g., inpatient, outpatient, intermediate care) is the most efficient as well as the most effective level. Initially, PSROs will place emphasis on the review of institutional services, especially those provided in the acute general hospital. Eventually, the scope of their review will be expanded to encompass all facets of the health delivery system.

According to the statute, the PSRO program must be substantially implemented over the course of the next two years. As estimated, 200 local PSROs must be established and operating as well as up to 20 Professional Standards Review (PSR) State Councils. The implementation of the program represents one of the most complex undertakings ever attempted by the Department. It requires the development of an innovative regulatory system that brings together the Government and the private sector in a unique cooperative relationship. In addition, the PSRO program must be made operationally effective in two massive but strikingly dissimilar programs, Medicare and Medicaid.

The following is an analysis of the priority PSRO implementation tasks that will be accomplished during 1974 and 1975:

A. General

Development and issuance of PSRO policies and policies for related programs such as utilization review, medical review, and independent professional review, including the definition of operating relationships of PSROs and PSR State Councils with providers, fiscal intermediaries and carriers, State Medicaid agencies, and related review programs.

Policies will be developed for: (1) the making of agreements with PSROs and PSR State Councils reimbursing their full administrative costs; (2) the provision of technical assistance and training to PSROs and PSR State Councils through DHEW regional and central office staff; (3) the definition of PSRO information and reporting requirements; (4) the definition of respective roles and responsibilities between PSROs and administrative instrumentalities such as Medicare intermediaries and carriers and Medicaid State agencies; (5) the development and management of a program to monitor and evaluate PSRO performance; (6) the coordination of Social Security Administration, Social Rehabilitation Services, and Public Health Service PSRO regional office activities under the direction of the Regional Health Administrator; and (7) administrative and staff support to the National PSRO Council.

B. PSRO Activities

(1) Area Designation. The first requirement of Section 249F is that the Secretary designate PSRO areas throughout the United States by January 1, 1974. The statute required a complex series of consultations with interested and affected local and State organizations prior to the designation of PSRO areas. Area designation criteria and guidelines have been developed and a broad range of data was assembled during the consultation process. PSRO area designations were announced as Notices of Proposed Rule Making in the *Federal Register* on December 20, 1973. Following the commenting period and analysis of the comments, PSRO area designations will be published as Notices of Final Rule Making.

(2) Initial PSRO Program Implementation. PSRO program implementation activities in 1974 will focus on the development of basic program policies, procedures, interim regulations, and operating guidelines relating to: (a) the conclusion of agreements with 50 PSROs and 6 State Councils; (b) operating relationships of PSROs with providers, intermediaries, and State agencies; and (c) the ongoing monitoring and evaluation of PSRO performance.

To successfully accomplish the above objectives, a large number of

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Regional office central staff

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
250	$5,909,000	Indefinite	250	$7,253,000

Purpose: This activity supports the immediate office of the Regional Health Administrators who are the principal health officials in the regions, responsible to the Assistant Secretary for Health for determining regional health policies; setting priorities, goals and objectives for the regions within the scope of national health policies; and administering all decentralized health programs and activities.

Explanation: The Regional Office Central Staff provides administrative and managerial support to the Regional Health Administrators in the implementation of decentralized health programs funded by appropriations for four of the six health agencies.

Accomplishments 1974: In 1974, the Regional Office Central Staff continued to provide the overall management capabilities necessary to administer the decentralized health program in the ten regional offices. Further decentralization of health programs during 1974, including major health manpower activities, has placed greater responsibility on the central staff. The level of grants administered in the regional offices increased by 56 percent over the 1973 level. In 1974, an intensive effort was made to assess the performance of all area-wide Comprehensive Health Planning Agencies and to provide direction and assistance to improve their operations where necessary.

Objectives in 1975: The primary focus of the Regional Office Central Staff in 1975 will be to make management and administrative improvements which will enhance the regional office capability to effectively implement their responsibilities as the operational arm of the Public Health Service with regard to decentralized programs. This will include continuing activities in effectively implementing the reorganization initiated in 1974. In addition, new procedures in operational planning and resource management will be implemented which will place major new responsibilities on the central staff.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Program direction and support services

1974			1975	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
507	$13,464,000	Indefinite	507	$14,146,000

Purpose: This activity supports the Office of the Assistant Secretary for Health. It provides staff support for the Assistant Secretary for guidance, leadership and direction to Public Health Service programs on all health and health-related activities, including research and development, education and training, organization, financing and delivery of health care services, preventive health care, and problems relating to unsafe foods and drugs.

Explanation: To provide funding for program direction and support services for the Assistant Secretary for Health.

Accomplishments in 1974: In 1974, the Administration's reorganization of the Public Health Service was implemented to more effectively meet the health needs of the people of the Nation. The Forward Plan for Health was prepared and much effort was spent in the development of a National Health Insurance Plan and other health policies and needs. Some 4,000,000 women received subsidized family planning services through organized programs. The number of nursing home employees receiving short-term training increased by some 60 percent over 1973.

Objectives for 1975: In the area of administrative management, procurement review procedures will be expanded to prevent unnecessary duplication among health agencies; optimum staffing standards will be initiated; and the recruitment of health professionals for the Public Health Service agencies will be strengthened and expanded. Particular emphases will be placed upon the potential impact of changes in health care financing, and the health impact on State and local fiscal and regulatory roles concerning health manpower requirements. There will be continued efforts to coordinate, consolidate, implement, and enforce standards for skilled nursing facilities and for intermediate nursing home care facilities.

Objectives for 1975: Agreements will be concluded with an additional estimated 70 PSRO's and 12 State Councils. Technical assistance will be provided to newly formed PSRO's and PSR State Councils in the conduct of such professional activities as review methods, the evaluation of existing utilization review committees, analyses of practice patterns and the mechanism for the rotation of reviewing physicians. PSRO's will be provided assistance and advice on the expansion of the scope of PSRO review activities from the acute general hospital setting to long-term care institutions and ambulatory practice. Policies, guidelines, and regulations will continue to be developed including the issuance of an operating manual for PSRO's and PSR State Councils as the program evolves through the various phases from planning, to conditional, to full operational. Evaluation activities will be initiated to assess the impact of PSRO's on health care, quality and cost, and to compare the performance of PSRO's and State Councils. It is estimated there will be 138 projects with PSRO's and State Councils by the end of 1975.

New Positions Requested

	1975		
	Grade	Number	Annual Salary
Professional standards review organizations			
Medical Officer....................	GS-15	12	$406,980
Public Health Program Specialist..	GS-15	3	84,789
Public Health Advisor.............	GS-14	11	266,717
Medical Care Administrator........	GS-14	3	72,741
Nurse.............................	GS-14	1	24,247
Public Health Program Specialist..	GS-14	10	242,470
Public Health Program Specialist..	GS-13	15	310,155
Public Health Advisor.............	GS-13	15	310,155
Medical Care Administrator........	GS-13	7	144,739
Medical Records Librarian.........	GS-13	1	20,677
Statistician......................	GS-13	1	20,677
Health Economist..................	GS-13	1	20,677
Public Health Program Specialist..	GS-12	10	174,970
Medical Care Administrator........	GS-12	3	52,491
Statistician......................	GS-12	2	34,994
Public Health Advisor.............	GS-12	8	139,976
Medical Care Administrator........	GS-11	3	44,013
Public Health Program Specialist..	GS-11	10	146,710
Medical Records Librarian.........	GS-11	1	14,671
Statistician......................	GS-11	2	29,342
Public Health Analyst.............	GS-11	5	73,355
Public Health Analyst.............	GS-9	6	73,002
Public Health Analyst.............	GS-7	2	19,938
Statistical Assistant.............	GS-7	3	29,907
Secretary.........................	GS-7	5	49,845
Clerical Assistant................	GS-7	6	59,814
Statistical Assistant.............	GS-6	2	17,954
Clerical Assistant................	GS-6	5	44,885
Secretary.........................	GS-6	6	53,862
Clerical Assistant................	GS-5	10	80,550
Secretary.........................	GS-5	6	48,330
Total new positions........		175	3,113,633

THURSDAY, APRIL 4, 1974.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

WITNESSES

DR. ROBERT VAN HOEK, ASSOCIATE ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION

LEE W. SMITH, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, PUBLIC HEALTH SERVICE

W. HARELL LITTLE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, HEALTH SERVICES ADMINISTRATION

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PROGRAM AND FINANCING

[In thousands of dollars]

	1973 actual	1974 estimate	1975 estimate
Program by activities:			
1. Retirement payments	14, 198	19, 828	23, 379
2. Survivors' benefits	200	224	300
3. Dependents' medical care	13, 708	14, 051	19, 743
Total costs, funded—obligations	28, 106	34, 103	43, 422
Financing: Budget authority (appropriation) (indefinite)	28, 106	34, 103	43, 422
Relation of obligations to outlays:			
Obligations incurred, net	28, 106	34, 103	43, 422
Obligated balance, start of year	9, 328	5, 499	6, 940
Obligated balance, end of year	−5, 499	−6, 940	−8, 891
Adjustments in expired accounts	−2, 205		
Outlays	29, 730	32, 662	41, 471

OBJECT CLASSIFICATION

[In thousands of dollars]

Benefits for former personnel	14, 398	20, 052	23, 679
Other services	13, 708	14, 051	19, 743
Total obligations	28, 106	34, 103	43, 422

Mr. FLOOD. Now we have the Retirement Pay and Medical Benefits for Commissioned Officers. The presentation will be made by Dr. Robert van Hoek, theAssociate Administrator of the Health Services Administration.

We have a biographical sketch of you we will place in the record at this point.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH OF ROBERT VAN HOEK, M.D.

Name: Robert van Hoek, M.D.

Position: Assistant Surgeon General (O8), PHS Commissioned Corps, Associate Administrator, Health Services Administration.

Birthplace and date: New York City, N.Y., July 1, 1927.

Education: 1944–49 B.S., City College of New York; 1949–53 M.D., College of Physicians and Surgeons, Columbia University; and 1958–59 Postgraduate Training and Radiobiology, Reed College, Portland, Oreg.

EXPERIENCE

January 1974 to present: Associate Administrator, Health Services Administration.

1972–73: Acting Director, National Center for Health Services Research and Development, Health Services and Mental Health Administration (HS).

1971–72: Deputy Administrator for Health Services Delivery, HS.

1969–71: Associate Administrator for Operations, HS.

1968–69: Director, Federal Health Programs Service, HS.

1967–68: Deputy Director, Division of Direct Health Services, Public Health Service (PHS).

1967–67: Chief, Officer of Research, Division of Direct Health Services, PHS.

1966–67: Acting Chief, Office of Training and Research, Division of Hospitals, PHS.

1965–66: Special Assistant to Assistant Chief for Training and Research, Division of Hospitals, PHS.

1964–65: Program Specialist, General Clinical Research Center Branch, Division of Research Facilities and Resources, National Institutes of Health (NIH).

1963–64: Trainee in Administration of USPHS Extramural Programs, Grants Associates Program, NIH.

1961–63: Head, Metabolism Branch of Radiation, Physiology Division, Armed Forces Radiobiology Research Institute, National Naval Medical Center.

1960–61: Chief Department of Biophysics, Walter Reed Army Institute of Research.

1959–60: Nuclear Medicine Officer, Walter Reed Army Institute of Research.

1957–58: Chief, Medical and Chest Section, Wright-Patterson Air Force Base Hospital.

1954–57: Resident, Internal Medicine, Bronx Veterans Administration Hospital.

1953–54: Intern, Medicine, St. Luke's Hospital (New York).

Memberships: Diplomate, American Board of Internal Medicine; Fellow, American College of Physicians; Member, American Federation for Clinical Research; and Member, Radiation Research Society.

Awards: Michael M. Davis Lecturer, 1973; PHS Distinguished Service Medal; PHS Meritorious Service Medal; and Alpha Omega Alpha Honor Medical Society.

Mr. FLOOD. I see you have a prepared statement. How do you want to handle it?

Dr. VAN HOEK. I would like to read it.

Mr. FLOOD. Suppose you do that.

Dr. VAN HOEK. Let me introduce Lee Smith, head of the Office of Personnel Management and Mr. Harell Little, Director, Office of Financial Management.

OPENING STATEMENT

Mr. Chairman and members of the committee: I am pleased to appear before you today to discuss the 1975 budget request for Retirement Pay and Medical Benefits for Commissioned Officers. This appropriation authorizes such amounts as may be necessary for certain mandatory payments under two programs.

PAYMENTS TO RETIRED OFFICERS AND SURVIVORS

The first program covers payments to retired officers of the Public Health Service and to survivors of deceased retired officers. Benefits to retired officers are authorized by section 211 of the Public Health Service Act, while those to survivors are authorized by the Retired Serviceman's Family Protection Plan. The request for $23.7 million for 1975, an increase of $3.6 million, is based on a projection of beneficiaries now being paid, with adjustments for anticipated additions and terminations. The number of retired officers [1,282 as of June 30, 1973], is expected to grow to 1,416 by June 1974 and 1,558 by June 1975. The number of survivors' annuitants [81 as of June 30, 1973] is expected to be 84 by June 1974 and 97 by June 1975.

DEPENDENTS' MEDICAL CARE

The Dependents' Medical Care Act and the Military Medical Benefits Amendments of 1966 authorize the provision of medical care to active duty and retired uniformed service personnel, their dependents, and dependents of deceased servicemen of the Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service. Expenses of the dependents' medical care program are for contract medical care furnished to dependents and retirees. The costs in Federal facilities are for inpatient care whereas the contract program pays for inpatient, outpatient care, and rehabilitative care for the physically handicapped and mentally retarded dependents of active duty servicemen.

The budget request is for $19.7 million in 1975. This represents an increase of $5.7 million which will provide $3.4 million for non-Federal care due to cost increases and $2.3 million for care in Federal facilities due to higher reimbursable rates.

SUMMARY

The total estimate for 1975 is $43.4 million which will provide $23.7 million for the retired officers and survivors program and $19.7 million for the dependent's medical care program.

I will be pleased to answer any questions you may have.

$9.3 MILLION INCREASE

Mr. FLOOD. This increase of $9.3 million is the largest increase we have had in 4 years. How do you explain that?

Dr. VAN HOEK. There are several reasons for that increase. About $3.6 million is for increases in retirement payments. There are in essence mandatory costs based on what we anticipate are the number of officers entering retirement as well as an increase in the number of annuitants, that is, survivors of retired personnel.

There is, in addition, $5.7 million for dependents' medical care which has two parts. One is the increase, approximately $2.3 million, for increased workload under the dependent's medicare program.

PRIVATE SECTOR WORKLOAD

Mr. FLOOD. Last year you attributed some of the 1974 increase to the fact you were closing out the Public Health Service hospitals and thus there would be more inpatient care to be provided by the private sector, of course, at a higher cost. Since the PHS hospitals are still open does your 1975 request assume this lower utilization by the private sector hospitals and greater utilization of PHS hospitals for inpatient care?

Dr. van Hoek. Yes, sir. The 1975 projection does anticipate an increased workload through the civilian health for Armed Forces program, but this increase is based primarily on the fact of a slight increase in the population base and is not predicated on the closure of the Public Health Service hospitals.

PHS COMMISSIONED CORPS RETIREMENTS

Mr. Flood. You are projecting in 1975, 125 officers retiring because of years of service. Are most of these officers retiring at 20 years of service?

Mr. Smith. That would represent approximately 65 officers who would retire with less than 30 years or full service.

Mr. Flood. Out of how many?

Mr. Smith. 125.

Mr. Flood. What do you project is the average number of years of service for those individuals who retire in 1974 and 1975?

Dr. van Hoek. In the past our experience has been on the average they are 55 years of age and have had 26 years of total service.

Mr. Flood. Are you finding it difficult to retain PHS officers beyond the 20th year?

Dr. van Hoek. No, sir. As a matter of fact the retirement requests have not significantly increased in recent years and the number of people as I recall has stayed about the same. As a matter of fact we believe that the number of people retiring this year will be less than in recent years.

Mr. Smith. It has been as high as 13 percent of eligibles. This year we anticipate it will be about 8 percent of the eligible group.

Mr. Flood. Thank you very much.

Dr. van Hoek. Thank you, Mr. Chairman.

JUSTIFICATION OF THE BUDGET ESTIMATES

Assistant Secretary for Health

Retirement Pay and Medical Benefits
for Commissioned Officers

Amounts Available for Obligation

	1974	1975
Appropriation (Indefinite)...............	$34,103,000	$43,422,000

Obligations by Activity

Page Ref.		1974 Estimate Amount	1975 Estimate Amount	Increase or Decrease Amount
213	Retirement payments.......	$19,828,000	$23,379,000	+$3,551,000
215	Survivors' benefits.......	224,000	300,000	+76,000
216	Dependents' medical care..	14,051,000	19,743,000	+5,692,000
	Total Obligations.......	34,103,000	43,422,000	+9,319,000 A/

Explanation of Changes

A/ Mandatory Increases

Obligations by Object

	1974 Estimate	1975 Estimate	Increase or Decrease
Benefits for former personnel...............	$20,052,000	$23,679,000	+$3,627,000
Other services...........	14,051,000	19,743,000	+5,692,000
Total obligations by object..............	34,103,000	43,422,000	+9,319,000

Summary of Changes

1974 estimated obligations	$34,103,000
1975 estimated obligations	43,422,000
Net change	+9,319,000

	Base Amount	Change from Base Amount
Increases:		
A. Built-in:		
1. Estimated costs for projections of retirements during 1974 to full year and for estimated additional retirements during 1975	$19,828,000	$3,551,000
2. Estimated increase in survivors' benefits	224,000	76,000
3. Estimated cost for increased inpatient and outpatient care of retirees and dependents	12,499,000	5,258,000
4. Estimated increase for ancillary services (drugs, handicapped care, contractors' fees, etc.) required by an expanding beneficiary population	1,552,000	434,000
Total, Increase	---	+9,319,000
Total, Net change	---	+9,319,000

Explanation of Changes

Increases:

A. Built-in:

1. The estimated increase of $3,551,000 will provide the full-year payments of officers retired during 1974, and for the net increase of 142 officers estimated to retire during 1975, and for the projected cost-of-living increase during 1975.

2. The estimated increase of $76,000 will provide for a net increase of thirteen survivors receiving benefits.

3. An estimated increase of $2,805,000 will provide for a 23% increase for inpatient care and a 19% increase for outpatient care. An estimated increase of $2,269,000 is due to an increase in reimbursable rates in the Federal sector. An estimated increase of $184,000 will provide for an anticipated higher workload.

4. An estimated increase of $434,000 will provide for higher handicapped program costs, drug usage costs, and contractors' fees. These increases are related to the rise in the number of beneficiaries eligible for care: 146,700 in 1974 and an estimated 155,600 in 1975.

Retirement Pay and Medical Benefits for Commissioned Officers

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1965	7.272.000	7,272.000	7.272,000	7.066,099
1966	7,850,000	7,850,000	7,850.000	7,833,800
1967	8,977.000	8,977.000	8,977,000	10,837,719
1968	13,391,000	13,391,000	13,391,000	11,290,000
1969	15,090.000	15,090.000	15,090,000	14,265,000
1970	16,700.000	16,700,000	16,700,000	16,567.000
1971	19.501,000	19.501,000	19.501,000	21,349,000
1972	23,196,000	23,196,000	23,196.000	23,960,000
1973	29.163,000	29.163,000	29,163.000	28,106,000
1974	34,103,000	34,103,000	34,103,000	34,103,000
1975	43,422,000			

Justification

Retirement Pay and Medical Benefits for Commissioned Officers

	1974 Amount	1975 Amount	Increase or Decrease Amount
Other expenses.........	$34,103,000	$43.422,000	+$9.319.000

General Statement

This appropriation provides for retirement payments to Public Health Service officers who have been or will be retired for age, disability. or length of service as well as for payments to the survivors of deceased retired officers who had received reduced retirement payments under the provisions of the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

Provision is also made for the cost of medical care provided in non-Public Health Service facilities to dependents of Public Health Service beneficiary members of the uniformed services and retired personnel in accordance with the Dependents' Medical Care Act as amended by Public Law 89-614.

Retirement Payments

	1974 Amount	1975 Amount	Increase or Decrease Amount
Other expenses............	$19,828,000	$23,379,000	+$3,551,000

This activity provides for mandatory payments to officers who have been retired for age, disability, or specified period of service in accordance with provisions of law. Seventeen officers will be eligible for age retirement during 1975, and provision is made for the retirement of 20 officers for disability and 125 officers for years of service.

On June 30, 1973, there were 1,282 officers on the retired roll. During Fiscal Year 1974 through December 31, 1973, 64 officers have been retired for years of service, 8 for age, and 10 for disability. It is estimated that a total of 154 officers will be retired during the fiscal year and 20 will be dropped from the roll, resulting in a total of 1,416 officers on the retired roll as of June 30, 1974.

It is estimated that 125 officers will be retired for years of service and 20 for disability during 1975. Since 17 officers will reach the mandatory retirement age of 64 years, provision has been made for the retirement of a total of 162 officers during 1975. It is estimated that 20 officers will be dropped from the roll during the year, resulting in a total of 1,558 officers on the retired roll as of June 30, 1975. A table showing the history of retirements since 1969 follows.

Retirement Table

Fiscal Years 1969 - 1975

	1969	1970	1971	1972	1973	Estimate 1974	Estimate 1975
Retired for:							
Disability...........	25	22	20	16	19	23	20
Age..................	10	18	20	13	16	19	17
Years of service.....	80	77	82	90	98	112	125
Other................	0	2	2	1	0	0	0
Total retirement...	115	119	124	120	133	154	162
Dropped:							
Death................	16	23	19	19	25	20	20
Other................	1	0	0	0	0	0	0
Total dropped......	17	23	19	19	25	20	20
Net increase or decrease in officers on retired roll, end of fiscal year.................	98	96	105	101	108	134	142
Officers on retired roll, end of fiscal year...	872	968	1,073	1,174	1,282	1,416	1,558

Survivors' Benefits

	1974 Amount	1975 Amount	Increase or Decrease Amount
Other expenses.............	$224,000	$300,000	+$76,000

This estimate provides for the payment of annuities to the survivors of deceased retired officers who elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

The estimate is based on payments to the survivors of the following numbers of officers:

June 30, 1972..........	73
June 30, 1973..........	81
June 30, 1974..(est.)..	84
June 30, 1975..(est.)..	97

Dependents' Medical Care

	1974 Amount	1975 Amount	Increase or Decrease Amount
Other expenses................	$14,051,000	$19,743,000	+$5,692,000

The Dependents' Medical Care Act (10 U.S.C., ch. 55), as amended by PL 89-614, provides for an expanded and uniform program of medical care for active duty and retired members of the uniformed services, and dependents of active duty, retired and deceased members. This activity covers the cost of inpatient and outpatient care (including care of handicapped dependents of active duty personnel) outside the Public Health Service, both in non-Federal and in uniformed service facilities, to dependents of eligible personnel of the Coast Guard, the National Oceanic and Atmospheric Administration, and the Public Health Service; and to retired personnel of these services.

A net increase of $5,692,000 is requested in 1975. In the non-Federal care area $3,423,000 is needed to cover the anticipated increase in rates and workloads for inpatient and outpatient care as well as for handicapped care, drugs and contractors' services. In the Federal care area, we anticipate an increase of $2,269,000 due to the increase in reimbursable rates.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Program Purpose and Accomplishments

Activity: Retirement pay (Public Health Service Act as amended, Sec. 211; 10 U.S.C., 1201)

	1975	
1974 Amount	Authorization	Budget Estimate Amount
$19,828,000	Indefinite	$23,379,000

Purpose: This authority provides for payments to commissioned officers of the Public Health Service who have been retired for age, disability, or specified period of service.

Explanation: Public Health Service officers do not contribute to the retirement fund. The fund is supported by the Federal Government through an annual appropriation.

Accomplishments in 1974: An estimated net increase of 134 officers will be added to the retirement rolls, resulting in a total of 1,416 retirees as of June 30, 1974.

Objectives for 1975: A net increase of 142 officers will result in an estimated total of 1,558 retired officers at the end of fiscal year 1975.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits
for Commissioned Officers

Program Purpose and Accomplishments

Activity: **Survivors'** benefits (10 U.S.C, ch. 73)

	1975	
1974 Amount	Authorization	Budget Estimate Amount
$224,000	Indefinite	$300,000

Purpose: Under the provision of the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan, retired personnel who elect to receive reduced amounts of retired pay are able to provide for monthly payments to be continued to their survivors.

Explanation: This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Accomplishments in 1974: It is estimated that there will be a total of 84 annuitants as of June 30, 1974.

Objectives for 1975: It is estimated that there will be a total of 97 annuitants as of June 30, 1975.

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits
for Commissioned Officers

Program Purpose and Accomplishments

Activity: Dependents' medical care (10 U.S.C., ch. 55)

	1975	
1974 Amount	Authorization	Budget Estimate Amount
$14,051,000	Indefinite	$19,743,000

Purpose: The Dependents' Medical Care Act as amended by PL 89-614 provides for an expanded and uniform program of medical care to active duty and retired members of the uniformed services, and dependents of active duty, retired, and deceased members.

Explanation: This activity is used to satisfy the mandatory obligations of the Public Health Service. They arise because a dependent or a retired person receives care in an approved hospital facility. The amount of the expense incurred varies, depending upon the medical facility that the Public Health beneficiary enters: (1) if care is given in a Public Health Service facility, there is no charge under the Dependents' Medical Care Act (these costs are chargeable to the appropriation, Health Services); (2) if care is given in a facility of another uniformed service, the Public Health Service is billed directly by that organization; and (3) if medical care is given in a private facility, a contractor such as Blue Cross pays the hospital and bills the executive agent in the Department of Defense, who in turn bills the Public Health Service for the services rendered.

Accomplishments in 1974: A daily average of 302 persons will be hospitalized, 16,300 outpatient claims will be processed and 197 handicapped dependents will receive care.

Objectives for 1975: This program is designed to provide care to an estimated 155,600 eligible beneficiaries, an increase of 8,900 over 1974. The level of funding requested will allow delivery of health care to this larger beneficiary population. Currently we are anticipating in contract hospitals an average daily load of 351, outpatient claims of 19,500 and handicapped cases of 217.

APPENDIX

(CLERK'S NOTE: The following information pertains to the Health Services Administration testimony and was requested earlier on pp. 129, 130, 144, and 150.)

MATERNAL AND CHILD HEALTH

SECTION 503 AND 516 FUNDING; MATERNAL AND CHILD HEALTH SERVICES

In 1974, Congress provided a $7 million supplemental appropriation which was allocated to 34 States under provisions of section 516 of the Social Security Act. These States were ones which would have received additional funds had the conversion from project grants to formula grants occurred as originally provided in title V legislation. However, Public Law 93–53 postponed the actual conversion until July 1, 1974.

For 1975, section 516 provided the mechanism for assuring that States receive as much in 1975 under the formula allocation as they did in 1973 under the combined formula-project program. Full implementation of this "hold-harmless" provision would have required $29.4 million for distribution under section 516 authority, $7 million of which was available in the 1975 base appropriation request, leaving a 1975 net "shortfall" of $22.4 million.

With only $7 million distributed under section 516 authority, 16 States would have had "shortfalls" ranging from $5,780,869 to $50,400, totaling $22.4 million.

Because of the severe impact of the "shortfall" under this distribution, it was decided to shift $18 million from section 503 to section 516, making a total of $25 million available. By taking this action, the severity of "shortfall" was reduced from the earlier levels mentioned to a range of $2,645,069 to $784.

As a result of transferring $18 million from section 503, the number of States facing "shortfall" increased from 16 to 23, and the full cost of implementing the "hold-harmless" provision changed from $29.4 million to $36.2 million. However, by distributing $25 million under section 516 authority, the unmet "shortfall" is $11.2 million ($36.2 million less $25 million) as compared to an unmet "shortfall" of $22.4 million ($29.4 million less $7 million) when only $7 million was distributed under section 516.

In addition, the Department has requested authority from Congress to apply $10,472,000 in released project grant funds from 1973 to projects in "shortfall" States, thereby further reducing the net "shortfall" to $731,690.

The 1975 columns of the maternal and child health services and crippled children's services formula grant tables, as shown on pages 85–86 and 90–91 of the "Justifications of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1975," U.S. Department of Health, Education, and Welfare, volume 1, reflect the conversion from project grants to formula grants required by title V legislation. The 1973 and 1974 columns in the tables show only those funds awarded as formula grants, since project grants under sections 508, 509, and 510 of title V continued to be awarded separately in those years.

The following table is done on a comparable basis for all 3 years by State to show both formula and project grants for maternal and child health, and crippled children's services. The 1973 column is based on funds allocated under the sections 503 and 504 formula grants, and amounts obligated for sections 508, 509, and 510 project grants; the 1974 column is based on funds allocated under sections 503, 504, and 516, and estimated obligations for sections 508, 509, and 510; and the 1975 column is based on funds allocated under sections 503, 504, and 516, as proposed in the President's budget.

In comparing the amounts received in 1973 by States for grants under sections 503, 504, 508, 509, and 510 with the amounts allocated in the President's budget for 1975 under sections 503, 504, and 516, 23 States show up as receiving less than they received in 1973.

To help alleviate this 1975 "shortfall" of $11,203,674, authority has been requested from Congress to apply $10,472,000 in released project grant funds from 1973 to projects in these 23 States in proportion to their "shortfall," as shown below.

BEST COPY AVAILABLE

MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN FUNDS
ALLOCATED UNDER SECTIONS 503, 504, 508, 509, 510, 516, AND TITLE V OF THE SOCIAL SECURITY ACT

States	1973 Formula Grants	1973 Project Grants	1973 Total	1974 Formula Grants	1974 Project Grants	1974 Total	1975 Formula Grants	Excess of 1975 Over 1974
TOTALS	$103,612,000	$111,273,000	$214,885,000	$110,612,000 1/	$111,273,000	$221,885,000	$221,885,000 2/	0
Alabama	2,599,200	2,927,948	5,527,148	2,551,900	3,391,591	5,943,491	5,324,800	$-618,691
Alaska	379,200	25,279	404,479	405,300	97,656	502,956	515,500	12,544
American Samoa	208,800	0	208,800	314,100	0	314,100	305,100	-9,000
Arizona	944,200	1,162,760	2,106,960	933,300	1,112,000	2,045,300	1,984,200	-61,100
Arkansas	1,517,100	1,260,382	2,777,482	1,568,700	1,264,542	2,833,242	2,775,000	-58,242
California	5,719,900	6,366,792	12,086,692	5,965,900	5,985,591	11,951,491	12,014,300	62,809
Colorado	1,052,100	3,291,660	4,343,760	1,067,800	3,219,310	4,287,110	3,619,300	-667,810
Connecticut	1,047,800	1,348,988	2,396,788	1,041,000	900,445	1,941,445	2,217,100	275,655
Delaware	432,700	0	432,700	507,400	0	507,400	726,400	219,000
District of Columbia	481,200	4,701,334	5,182,534	476,500	4,525,055	5,001,555	3,783,800	-1,217,755
Florida	3,245,200	4,255,874	7,501,074	3,183,300	4,475,243	7,658,543	7,079,200	-579,343
Georgia	3,303,500	2,750,896	6,054,396	3,492,900	3,016,251	6,509,151	6,352,900	-156,251
Guam	313,600	0	313,600	332,800	0	332,800	387,000	54,200
Hawaii	500,700	886,247	1,386,947	505,300	467,864	973,164	1,222,800	249,636
Idaho	544,800	322,223	867,023	585,900	387,087	972,987	981,600	8,613
Illinois	3,507,300	7,612,380	11,119,680	3,564,200	7,834,848	11,399,048	9,837,300	-1,561,748
Indiana	2,755,100	378,768	3,133,868	3,318,500	421,915	3,740,415	5,406,300	1,665,885
Iowa	1,610,300	181,000	1,791,300	1,919,200	208,790	2,127,990	3,025,800	897,810
Kansas	1,097,100	983,811	2,080,911	1,110,500	1,083,941	2,194,441	2,045,200	-149,241
Kentucky	2,457,100	716,163	3,173,263	2,863,300	1,024,201	3,887,501	4,652,500	764,999
Louisiana	2,674,800	2,426,322	5,101,122	2,771,300	2,490,636	5,261,936	5,172,500	-89,436
Maine	701,600	67,877	769,477	849,000	210,366	1,059,366	1,378,200	318,834
Maryland	1,925,700	5,676,332	7,602,032	1,932,500	5,013,853	6,946,353	6,494,800	-451,553
Massachusetts	1,740,700	4,209,326	5,950,026	1,793,900	2,894,640	4,688,540	5,210,100	521,560
Michigan	3,949,200	5,261,708	9,210,908	3,997,200	5,431,179	9,428,379	8,815,700	-612,679
Minnesota	2,034,800	1,999,626	4,034,426	2,065,800	2,176,390	4,242,190	3,971,800	-270,390
Mississippi	2,193,000	304,383	2,497,383	2,605,200	393,257	2,998,457	4,123,900	1,125,443
Missouri	2,300,000	1,592,569	3,892,569	2,538,000	2,634,732	5,172,732	4,554,500	-618,232
Montana	490,300	377,339	867,639	509,200	250,300	759,500	872,200	112,700
Nebraska	812,900	1,694,620	2,507,520	809,200	1,167,124	1,976,324	2,182,800	206,476
Nevada	416,100	205,200	621,300	416,800	102,400	519,200	594,000	-74,800
New Hampshire	476,300	174,099	650,399	525,900	202,600	728,500	833,700	105,200
New Jersey	2,203,300	780,604	2,983,904	2,564,500	821,303	3,385,803	4,319,600	933,797

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MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN FUNDS
ALLOCATED UNDER SECTIONS 503, 504, 508, 509, 510, 516, AND TITLE V OF THE SOCIAL SECURITY ACT

State	1973 Formula Grants	1973 Project Grant	1973 Total	1974 Formula Grants	1974 Project Grants	1974 Total	1975 Formula Grants	Excess of 1975 Over 1974
New Mexico	711,200	592,726	1,303,926	749,000	614,242	1,363,242	1,362,700	-542
New York	5,109,400	13,675,469	18,784,869	5,135,100	14,644,267	19,779,367	16,139,800	-3,639,567
North Carolina	4,025,300	1,034,000	5,059,300	4,635,600	1,038,246	5,673,846	7,406,400	1,732,554
North Dakota	490,100	-	490,100	584,300	-	584,300	842,200	257,900
Ohio	4,810,600	5,371,518	10,182,118	4,812,900	5,903,838	10,716,738	[illegible]	[illegible]
Oklahoma	1,376,800	660,000	2,036,800	1,532,000	760,000	2,292,000	2,548,500	256,500
Oregon	1,137,100	976,261	2,113,361	1,212,400	921,236	2,133,636	2,247,400	113,764
Pennsylvania	5,282,400	5,016,205	10,298,605	5,413,500	4,737,952	10,151,452	10,280,000	128,548
Puerto Rico	3,257,200	4,902,610	8,159,810	2,946,100	5,234,554	8,180,654	7,340,300	-840,354
Rhode Island	514,600	229,584	744,184	515,200	230,000	745,200	743,400	-1,800
South Carolina	2,328,800	872,986	3,201,786	2,674,200	797,861	3,422,061	4,448,000	975,939
South Dakota	503,400	-	503,400	603,500	-	603,500	917,400	313,900
Tennessee	2,662,800	802,848	3,465,648	3,070,000	948,826	4,018,826	4,946,400	927,574
Texas	5,513,800	4,335,570	9,849,370	5,877,200	5,992,000	11,864,200	10,500,100	-1,369,100
Trust Territory	282,800	-	282,800	369,400	-	369,400	455,500	86,100
Utah	767,700	47,000	814,700	962,900	121,115	1,084,015	1,590,200	506,185
Vermont	401,300	-	401,300	473,400	160,449	633,849	696,200	62,351
Virgin Islands	308,500	683,000	991,500	309,100	633,000	942,100	798,800	-143,300
Virginia	2,837,600	1,983,265	4,820,865	3,014,500	1,953,080	4,967,580	5,189,500	221,920
Washington	1,623,100	508,033	2,131,133	1,954,100	934,261	2,888,361	3,372,600	484,239
West Virginia	1,387,800	587,085	1,974,885	1,527,100	619,000	2,146,100	2,500,900	354,800
Wisconsin	2,272,300	100,000	2,372,300	2,754,100	100,000	2,854,100	4,380,500	1,526,400
Wyoming	371,500	-	371,500	400,100	-	400,100	478,200	78,100
Undistributed		4,952,330	4,952,330		1,723,963	1,723,963		-1,723,963

1/ Includes $7 million distributed in accordance with the provisions of Section 516. In 1974 only, the States may use these funds for either maternal and child health services or crippled children's services.

2/ Includes $25 million distributed in accordance with the provisions of Section 516.

States	Shortfall based on President's budget	Allocation of released funds	Remaining shortfall
Total	$11, 203, 690	$10, 472, 000	$731, 690
Alabama			
Arizona	202, 348	189, 100	13, 248
Arkansas	122, 760	114, 700	8, 060
California	2, 482	2, 300	182
Colorado	72, 392	67, 700	4, 692
Connecticut	724, 460	677, 100	47, 360
District of Columbia	179, 688	167, 900	11, 788
Florida	1, 398, 734	1, 307, 400	91, 334
Hawaii	421, 874	394, 300	27, 574
Illinois	164, 147	153, 400	10, 747
Kansas	1, 282, 380	1, 198, 700	83, 680
Maryland	35, 711	33, 400	2, 311
Massachusetts	1, 107, 232	1, 034, 900	72, 332
Michigan	739, 926	691, 600	48, 326
Minnesota	395, 208	369, 400	25, 808
Nebraska	62, 626	58, 500	4, 126
Nevada	324, 720	303, 500	21, 220
New York	27, 300	25, 500	1, 800
Ohio	2, 645, 069	2, 472, 400	172, 669
Pennsylvania	263, 018	245, 800	17, 218
Puerto Rico	18, 605	17, 400	1, 205
Rhode Island	819, 510	766, 000	53, 510
Virgin Islands	[1] 800	800	----------------
	192, 700	180, 200	12, 500

[1] Rounded upward from $784.

INFANT MORTALITY

We believe that lowering of infant mortality rates occurs because of the following activities:

(1) Providing services early (in the first trimester).

(2) Providing services of high quality.

(3) Assisting mothers with such help as transportation and babysitting facilities.

(4) Providing nutrition, social, nursing, and other services at home before and after delivery.

(5) Mothers and infants who are found to be "high risk" are followed closely by qualified personnel and their cases are managed by skilled project staff. They receive the care they need when it's needed.

MIGRANT HEALTH

MIGRANT HOSPITALIZATION DEMONSTRATION PROGRAM

PARTICIPATING PROJECTS AND HOSPITALS

Project	Hospital	Location	Estimated amount
Lee County Health Department	Lee Memorial Hospital	Fort Myers, Fla	$215, 000
Coastal Bend Migrant Project	Robstown Riverside Hospital	Robstown, Tex	305, 000
Catholic Charities	Valley Baptist Hospital	Harlingen, Tex	1, 300, 000
Plan de Salud del Valle	Colorado General Hospital	Denver, Colo	90, 000
	Brighton Community Hospital	Brighton, Colo	----------
Arizona Job College	Homaeko Community Hospital	Casa Grande, Ariz	120, 000
	University Hospital	Tucson, Ariz	----------
Watcom-Shaget Rural Opportunity Council.	Skaget Valley Hospital	Mt. Vernon, Wash	210, 000
(Project not awarded)			760, 000
Total			3, 000, 000

Note: Distribution of funds indicated is based upon project service populations and initial projections of likely hospital utilization by those populations.

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INFANT MORTALITY RATE

MATERNITY AND INFANT CARE PROJECTS*

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
						33.2				31.1		
St. Louis (City)						26.0				14.0	12.0	
Hartford									25.2			
Providence					47.4						27.2	
District of Columbia	34.9								21.3			21.9
Chester, Pennsylvania											21.9	20.4
Baltimore			31.0	26.8							21.5	
Philadelphia				29.7				16.5		12.9		9.0
Richmond, Virginia						22.7				14,9	13.7	12.2
Albuquerque											18.3	12.0
Ponce, Puerto Rico											27.4	20.0
Northeast, Puerto Rico												16.5
Erie County, New York				22.7						24.4		
New York City (9 Project area served)				33.2				39.5			23.2	
Minneapolis										28.5		
Cleveland				32.3								

*Supported under Section 508 of Title V, Social Security Act.

MATERNITY AND INFANT CARE PROJECTS*

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
Cincinnati			23.6								19.8	
Augusta, Georgia (Rural)			51.4						28.3			
Augusta, Georgia (Includes Richmond Co.)			38.8						22.8			
Charleston, South Carolina	22.3							20.1				
Halifax County, North Carolina					39.4					28.8	34.4	
Warren County, North Carolina					55.7					20.3	22.2	
Wayne County, North Carolina					29.4					18.1	26.4	
Bell County, Kentucky		29.2		24.6					20.1		21.9	
Floyd County, Kentucky		23.2		28.6					17.4		18.7	
Letcher County, Kentucky		34.5		33.7					16.8		19.1	
Mobile				29.1							16.2	
Palm Beach				29.2					25.7			
Orlando										17.0	6.0	
Harlan County, Kentucky		26.6									27.7	

*Supported under Section 508 of Title V, Social Security Act.

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INFANT MORTALITY RATE

MATERNITY AND INFANT CARE PROJECTS*

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
Washoe County, Nevada					24.6							23.3
Los Angeles, Calif. (East Health District)					17.5						15.2	
Los Angeles, Calif. (South Health District)					31.7						27.5	
Little Rock, Arkansas					26.3	22.8					19.5	
Houston, Texas			27.9					21.4		21.0	20.6	
Grayson County, Texas			24.2							15.7	13 5	
St. Louis (County)						17.4				15.6		
Adams County, Colorado				13.6			16.3				11.3	
Arapohoe County, Colorado				16.2				9.6			11.3	
Chicago, Illinois				33.6					27.7			
Detroit, Michigan					28.0		26.8					
Pittsburgh							22.5					16.2
Morgantown, West Virginia								15.4			17.4	
Charleston, West Virginia									49.5		21.6	

*Supported under Section 508 of Title V, Social Security Act.

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INFANT MORTALITY RATE

MATERNITY AND INFANT CARE PROJECTS*

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
St. Paul							27.6			35.5	16.6	
Indianapolis										42.2	26.1	
Omaha					19.9						17.6	
Newark		34.9	43.0							34.6	22.6	23.2
Dade County, Florida		24.6	23.7								15.9	2.5[1/]
Denver[2/]				28.1				21.4			17.8	
Gainesville				29.41							17.67	
Seattle				20.9						21.4	13.7	
Portland, Oregon (City)			21.4						20.7			
Portland, Oregon (County)			23.0						15.2			
Birmingham				25.4							17.4	
Tuskeegee (9 county average)				35.0							30.0	
Honolulu					26.3					11.3	25.6	
Berkeley					21.3				14.2	13.3		

*Supported under Section 508 of Title V, Social Security Act.

[1/] This rate is the most recent available and covers the first six months of 1973.

[2/] Neonatal rather than infant mortality rates are reflected in the justification.

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INFANT MORTALITY RATE

MATERNITY AND INFANT CARE PROJECTS*

No Data Readily Available	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
Augusta, Maine												
Boston, Massachusetts												
Fort Lauderdale, Florida												
Atlanta, Georgia												
Jackson, Mississippi												
Greenville, South Carolina												
Reno, Nevada												
Boise, Idaho												

*Supported under Section 508 of Title V, Social Security Act.

SPECIAL REPORTS

Mr. FLOOD. We have several excellent special reports that were prepared for the committee by Health, Education, and Welfare which we will insert in the record at this point.

[The reports follow:]

BLACK LUNG DISEASE (COAL WORKERS' PNEUMOCONIOSIS)

Obligations
(in thousands)

	1971	1972	1973	1974 Estimate	1975 Estimate
Public Health Service:					
Center for Disease Control National Institute for Occupational Safety and Health	$5,689	$6,138	$3,317	$9,143	$5,300
National Institutes of Health National Heart and Lung Institute	100	120	163	200	250
Total	5,789	6,258	3,480	9,343	5,550

Black lung disease, or coal workers' pneumoconiosis, is an incapacitating, life-shortening constellation of disease processes initiated by the inhalation and retention in the lungs of coal and other mine dusts.

Black lung disease kills more Americans than all other forms of pneumoconiosis (the various dust-inhalation diseases) combined, and afflicts approximately 100,000 living Americans. While it is largely preventable by the use of known methods of minimizing exposure to dust, the disease is irreversible once established.

Thus, complete control of black lung disease in this country requires extensive application of known preventive measures, and basic and clinical research to learn where and how we may intervene to slow or halt the progression of the underlying disease processes.

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CENTER FOR DISEASE CONTROL

National Institute for Occupational Safety and Health

Activity Under the Federal Coal Mine Health and Safety Act of 1969 (P.L. 91-173)

Under provisions of the Federal Coal Mine Health and Safety Act of 1969 (P.L. 91-173), as amended, the National Institute for Occupational Safety and Health is the Department's primary program dealing directly with health of coal miners. The National Institute provides a research and technical service to raise the health status of workers through prevention and control of occupational diseases.

In 1972 the National Institute for Occupational Safety and Health (NIOSH) completed the first round of medical examinations of underground coal workers under provisions of Title II of the Federal Coal Mine Health and Safety Act of 1969. This first effort covered 72,504 coal workers who availed themselves of the opportunity for these examinations. In addition, approximately 1,000 coal workers at surface coal mines were examined to identify any unusual health problems from this type of employment. In late 1973, the second round of medical examinations called for by the Act was initiated and about 6,000 miners participated. By the completion of this round in 1975 it is hoped that 90,000 of the approximately 110,000 underground coal miners will avail themselves of the medical examination opportunity.

In 1974 NIOSH will begin to review and record audiograms conducted on miners under approved programs. Mines which have been found to be in violation of noise standards are required to effect a program of noise control and provide the audiology. At the present time about 4,000 underground mines are included in this program and it is anticipated that the numbers will increase in 1975. During 1974 NIOSH is initiating a program, through grants and contracts, for the provision of diagnostic and treatment services for active and inactive miners suffering from respiratory disease. This one-year funding will support approximately 25-30 clinics which should become self-sufficient through the third party pay mechanism.

In addition, in 1975 the NIOSH proposes to develop mandatory health standards, preventive examination programs, and protective engineering techniques to assure that coal workers are provided a working environment which will prevent occupationally caused diseases, by:

(a) Continuing the second round of medical examinations of the 90,000 underground coal miners in order to assure detection of physical impairment due to unhealthful working environments in accordance with the Federal Coal Mine Health and Safety Act;

(b) Providing for an estimated 400 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung Benefits;

(c) Developing and conducting research to develop techniques for the prevention and control of occupational diseases of coal miners and persons who work with or around the products of coal mines, in areas outside of such mines.

NATIONAL INSTITUTES OF HEALTH

National Heart and Lung Institute

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The National Heart and Lung Institute bears primary responsibility for basic and clinical research concerned with the respiratory (pulmonary) system and with developing improved methods for the prevention, diagnosis, and relief of chronic lung diseases (other than the infectious and malignant lung diseases, which are the special provinces of the National Institute of Allergy and Infectious Diseases, and the National Cancer Institute, respectively).

In partial fulfillment of this mission, the NHLI Division of Lung Diseases spent $371,500 in support of four regular research grants and five subprojects within Specialized Center of Research (SCOR) pulmonary programs for research on certain of the pneumoconioses. This is a collective term for a number of different diseases caused by the inhalation and retention in the lungs of mineral or vegetable dusts and including such diseases as silicosis, asbestosis, byssinosis, and--the subject of this report--coal workers' pneumoconiosis, or black lung disease. Approximately half of this sum was spent for research directly on black lung disease.

Magnitude of the Problem

Black lung disease is believed to account for more deaths--approximately 1,000 per year in this country--than all other forms of pneumoconiosis combined, and afflicts an estimated 90,000 to 125,000 U.S. miners. According to a 1967 report by the Pennsylvania Department of Public Health, 40,000 Pennsylvania coal miners had X-ray evidence of coal workers' pneumoconiosis and more than half of these (nearly 24,000 miners) were disabled by it. A recent nationwide survey by the U.S. Public Health Service and the U.S. Bureau of Mines indicates that nearly 30 percent of working coal miners in the U.S. have black lung disease.

Typically, victims of black lung disease require a decade or more of exposure to mine dusts before they are incapacitated or killed by the disease. In the interim, they experience progressively severe wheezing, coughing, and shortness of breath, and increased susceptibility to colds and other respiratory infections including tuberculosis.

Black Lung: A Composite of Several Disorders

The progressive, irreversible nature of the disease is revealed by autopsy examination of lung tissues following varying periods of exposure to the mine dusts.

This also shows that the disease actually involves five or more different disease processes:

- Some of the inhaled dusts are retained and become permanently incorporated into the walls of the small air passages (bronchioles) and sacs (alveoli) to form microscopic, focal deposits called macules. In aggregate, these macules are grossly visible as blackened patches and streaks in lung slices following only a few years of dust exposure.

- Destruction of lung tissue around the dust deposits produces a halo of emphysema--in effect, a dead air space--around each macule.

- In some patients, scar tissue formation (fibrosis) occurs between macules,

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and can involve large areas of the lung. While the occurrence and severity of fibrosis are unpredictable, fibrosis has been associated in some studies with exposure to silica dust, and in others with tuberculosis.

- The eventual development of chronic bronchitis and the more generalized forms of emphysema contribute importantly to shortness of breath and disability in coal workers' pneumoconiosis.

- Finally, many afflicted workers exhibit as a complication of their disease elevated blood pressure in the lungs (pulmonary hypertension) and, as a consequence of this increased pressure, compensatory enlargement of the right side of the heart.

Heart failure is the most common cause of death in persons with black lung disease; many others succumb to respiratory failure during an acute respiratory infection.

Treatment

There is no form of treatment that will halt, much less reverse, the slow course of black lung disease. Available therapy is aimed either at complications of the disease, or at relieving some of its symptoms. Antibiotics are used to treat respiratory infections, and cardiotonic drugs enable the heart to pump more blood through remaining lung tissue. Also available are a number of drugs to ease breathing by dilating air passages or by dissolving obstructive mucus secretions, and intermittent positive-pressure breathing apparatus for severe respiratory distress. Research continues on other ways of ameliorating the symptoms and complications of black lung disease.

Prevention

Prevention is the only known way of controlling black lung disease and, as studies in Great Britain have demonstrated, is quite effective. This is accomplished by reducing dust levels in working environments, and limiting the duration of exposure to dust. Specific measures include the use of dust monitoring systems; wetting practices, air filters, dust masks and other equipment to collect or suppress dust at its source or remove it from the atmosphere; improved ventilation systems; rearranging work shifts to reduce individual exposure to particularly dusty environments; periodic X-ray examinations and pulmonary function tests to detect the disease in its early stages; and other screening tests to identify job-applicants and others who are especially susceptible to the disease. People with an hereditary deficiency of the enzyme alpha-1-antitrypsin are more likely to develop black lung disease, in a particularly severe form in terms of both the earlier onset and relatively more rapid progression of the disease. And, for reasons as yet unknown, workers who have either tuberculosis or rheumatoid arthritis together with black lung are especially prone to develop massive pulmonary fibrosis.

Finally, anti-smoking campaigns and above-ground air pollution control activities are (or should be) important elements of any effort to control black lung disease. These additional airborne insults to the lungs aggravate the symptoms and accelerate the course of the disease.

In Great Britain, where coal workers' pneumoconiosis was first described and control measures initiated 30 years ago, mortality and disability from black lung has been halved. Complete control of the disease in this country, including help for those who already have black lung, requires extensive application of known preventive measures and the acquisition of new information concerning the underlying disease processes.

Need for Research

We need to know more about the relationships between these processes, whether they occur simultaneously or sequentially, and correlate them in turn with other internal and environmental factors operant in the disease's several phases. Only in this way can we hope to find a weak link in the chain of events that all too often culminates in disability and death--a link that we can break with appropriate therapy to arrest the disease process.

Current Research Efforts

The research approach outlined above is being pursued in the principal NHLI grant-supported study of black lung disease. The study, conducted by Dr. Richard L. Naeye at the Pennsylvania State University, is a combined clinical-epidemiological-pathological investigation of the five or more disease processes that constitute coal workers' pneumoconiosis. This comprehensive project, now in its eighth year at a current annual funding level of $78,000, will include autopsy studies of 500 coal workers, 300 miners' wives, 650 people not associated with the coal mining industry, and 400 rural Pennsylvanians matched for age and race with other groups.

Though not completed, this study has already yielded interesting findings correlating types and severities of disease manifestations with exposure to silica dust at different mine sites and in soft and hard coals.

In separate studies, Dr. Naeye and other NHLI grantees, including Dr. Edward A. Gaensler at Boston University School of Medicine, have confirmed that respiratory impairment and functional disability cannot be determined with any degree of accuracy from chest X rays, even though X rays are capable of accurately detecting the presence and progression of dust deposits, fibrosis, and other tissue changes associated with the pneumoconioses. The finding reflects the composite nature of black lung disease and the fact that each of the multiple disorders comprising the disease may vary in incidence and severity from one patient to another.

Health Education

Because health education and public information are key elements in any effort to combat a public health problem, the NHLI recently published a 16-page illustrated brochure that describes the various dust inhalation diseases, including black lung, and outlines the causes, symptoms, diagnosis, prevention, and treatment of the pneumoconioses.

VENEREAL DISEASES

Obligations (in thousands)

	1971	1972	1973	1974 Estimate	1975 Estimate
Public Health Service:					
Center for Disease Control.....	$12,134	$28,230	$31,340	$31,340	$32,533
National Institutes of Health					
National Institute of Allergy and Infectious Diseases........	128	455	1,205	2,200	2,200
Total...................	12,262	28,685	32,545	33,540	34,733

Venereal disease is one of the most serious and insidious health problems confronting the United States today. Reported cases of gonorrhea have been increasing yearly at the alarming rate of 10 to 15 percent, while the number of infectious syphilis cases reported in 1972 was three percent higher than in the previous year. Late in FY 1972, primarily through increased project grant appropriations, syphilis control programs throughout the country were intensified, and reported syphilis incidence has once again begun to level off. During the first 3 months of FY 1974, early infectious syphilis cases were down .4% compared to the same period in FY 1973. A nation-wide attack on gonorrhea, implemented late in FY 1972, is resulting in the identification of large numbers of women with gonorrhea, most of whom have no noticeable symptoms. Because of this casefinding activity, female cases were up 22.5% during the first 3 months of FY 1974; male cases appear to be leveling off. As the "hidden" reservoir of asymptomatic disease is reduced, it is expected that reported cases in both sexes will decline.

Research activities are carried out primarily through programs of the Center for Disease Control and the National Institute of Allergy and Infectious Diseases. Research priorities include the development of improved diagnostic and screening methods for gonorrhea, and studies related to the immunology of both syphilis and gonorrhea. A comprehensive program of both basic and applied research in these areas is being carried out.

CENTER FOR DISEASE CONTROL

Since the early 1930's, venereal disease control efforts have been a continuously shared responsibility of all levels of government. These control efforts over the years have had a profound impact upon the prevalence of syphilis. Total reported cases of syphilis decreased from a high of 575,593 cases in FY 1943, to 90,609 cases in FY 1973. The treatment of large numbers of syphilis cases has resulted in a significant decline in congenital syphilis and the late sequelae of syphilis. For the years for which comparable data are available, reported cases of congenital syphilis declined 85%, infant deaths due to syphilis declined 99%, deaths among adults due to syphilis declined 87% and first admissions to mental institutions with syphilitic psychoses declined 98%.

Syphilis

The reported incidence of syphilis has fluctuated through the years. During the 1940's, reported cases of infectious syphilis rose sharply, reaching a peak of 106,539 cases in FY 1947. During the following 10 years, the incidence declined 94% to a low of 6,251 cases. With reduced Federal support, reported cases of infectious syphilis increased 6.6% in FY 1958. This small increase was followed by dramatic increases, and by FY 1962, reported cases of infectious syphilis had increased by more than 200%. Syphilis control efforts, with major emphasis on case prevention, were intensified in FY 1962. However, cases continued to increase, reaching a high of 23,250 cases by FY 1965. Beginning with 1966, cases declined by almost 1,000 annually until 1970, when they again began to increase. The 24,080 cases reported in FY 1973 represent an increase of 1,080 cases (4.5%) over 1972 and are the greatest number of reported infectious syphilis cases since 1950.

Thus, while the overall level of syphilis and the occurrence of serious manifestations of the disease have been dramatically reduced, there remains the challenge to reduce the occurrence of new cases. Programs today are being directed toward the prevention of new cases, as measured by the trend of cases in the early infectious stage, to prevent a return to the 1930-1940 era when there were large numbers of people with long-term and debilitating disease.

Gonorrhea

The reported incidence of gonorrhea increased rapidly during the 1940's, reaching a peak of 400,639 in FY 1947. With the introduction and wide use of penicillin, gonorrhea declined gradually reaching a low of 216,476 cases in FY 1957. Reported cases began to rise again in FY 1958, and this trend has continued. The 809,681 cases reported in FY 1973 represent a 12.7% increase over the 718,401 cases reported in FY 1972, and is the highest reported incidence since the collection of national data began. When underreporting and underdiagnosis of cases are considered, the true incidence of gonorrhea is estimated at 2.5 million cases annually and the prevalence of disease among females is estimated at between 600,000 and 800,000. Gonorrhea continues to be reported most frequently from large urban areas; cities of 200,000 and more population, which constitute 28% of the total population, accounted for over 56% of all reported cases during FY 1973. For FY 1973, reported cases of gonorrhea among females numbered 304,975, an increase of 36.3% over the 223,749 cases reported in FY 1972. During this same period, cases of gonorrhea among males rose only 2.0%, the lowest rate of increase among males in the past decade. The difference in rates of increase between males and females is attributed to the impact of gonorrhea control efforts begun nationally in FY 1972.

Age-specific rates for [illegible]ious syphilis and gonorrhea show the age group 20-24 to be at the gr[illegible] risk of acquiring disease. Among gonorrhea patients, the 15-19 age gro[illegible] the second highest risk group, while for syphilis victims it is the 2[illegible] age group.

Statistics

With infectious syphilis at its highest reported level since 1950 and gonorrhea at the highest level ever reported in the United States, major emphasis continues to be placed upon the development and implementation of control programs for venereal disease. Particular emphasis is focused on disease intervention activities as the preferable and cost-beneficial strategy offering the best means of rapidly reducing the incidence of these diseases. The major control program areas focusing on disease intervention activities are: (1) screening, by bacteriologic culture, high-risk female populations for gonorrhea; (2) syphilis surveillance through the serologic screening of age groups and specific population segments; (3) the application of the epidemiologic process to all infectious and potentially infectious syphilis patients and to male cases of gonorrhea diagnosed in public clinics; (4) educational efforts directed toward communicating pertinent venereal disease facts to people at risk, with the objectives of preventing exposure or re-exposure to infection and influencing infected individuals to seek early diagnosis and treatment; and (5) the active involvement of the private medical community in all aspects of venereal disease control.

Screening programs for gonorrhea during FY 1973 caused 4,939,592 culture specimens to be obtained from females, of which 242,276 (4.9%) were found to be positive for gonorrhea. During the first three months of FY 1974, gonorrhea screening programs obtained culture specimens from an additional 1,833,958 females, of which 88,210 (4.8%) were positive for gonorrhea. Although the positivity rates were highest (19.8%) among venereal disease clinic patients, only 11% of all test specimens were obtained in such clinics. Some 89% of all test specimens were obtained in settings other than venereal disease clinics, and in these settings, positivity rates ranged from a low of 1.4% among female dependents of military personnel to a high of 5.9% among enrollees in manpower training programs. Private physicians obtained test specimens from 494,529 females, of which 10,589 (2.1%) were positive for gonorrhea. Provisional data for October, November and December 1973 indicate that 1,844,459 additional specimens from females were obtained from participating facilities, of which 4.8% were positive for gonorrhea. In addition to screening efforts, gonorrhea control activities include the application of the epidemiologic process to male patients who voluntarily seek medical attention. During the first three months of FY 1974, 24,159 named sexual contacts were followed and provided bacteriologic cultures for gonorrhea. Of these cultures, 8,888 (36.8%) were positive for gonorrhea. This process complements screening activities by providing for the broadest possible medical coverage for high-risk females. It is estimated that this combined effort will result in the prevention of more than 100,000 new cases of gonorrhea during FY 1974.

Case detection and surveillance activities of the syphilis control effort tested an estimated 40 million persons for syphilis during FY 1973. Of these, 1,[illegible]00,000 had reactive test results, and over 66,000 were identified as infected with syphilis. Application of the epidemiologic process to infectious syphilis cases resulted in the medical examination of 47,831 persons, of whom 7,162 (15%) were brought to treatment with previously undetected syphilitic infection. It is estimated that epidemiologic efforts alone will result in the prevention of 2,700 new cases of syphilis in FY 1974.

Control Efforts

Intensified syphilis control efforts, designed to reverse the trend of increasing syphilis incidence, have been implemented. Data from the first quarter of FY 1974 show a rate of decrease in incidence of 0.4% over the previous year and suggest that these intensified control measures are beginning to take effect. Other program activities being intensified include the areas of clinic services, program evaluation methods, disease intervention tools, and consumer involvement.

Because the population is extremely mobile and a high rate of interstate and international transmission of venereal disease occurs, control program efforts are directed at ensuring a rapid exchange of vital epidemiologic data among states, local health departments and international jurisdictions. During FY 1973, more than 12,000 sexual contacts to known syphilis cases resided in areas other than those in which the original patients received treatment and 9.2% of the contacts examined were found to be infected with syphilis. To insure the examination of the more than 700 contacts to infectious venereal disease named annually who reside outside the United States, all State and local health departments rely upon the CDC to process, translate, forward and feed back the results of exchanges with more than 60 international jurisdictions.

A Venereal Disease Communications Plan, providing the formal framework for a national information-education program, has been developed and implementation has begun. This plan consolidates objectives and message parameters to the general public, people at risk, health providers, physicians, members of organized groups, and to individual volunteers. The objective is to change attitudes and behavior in order to increase self-referrals for diagnosis and treatment and to permit health care providers to conduct appropriate programs involving screening, contact tracing, diagnosis, and treatment. As a part of this educational effort, an informational interchange has been initiated. Prototype materials developed by the CDC and educational materials, ideas and programs collected from State and local health departments, have been distributed throughout the country.

A national survey is underway of the extent and characteristics of venereal disease education in schools. It is designed to study a representative random sample of public and private schools within each State to determine the extent to which venereal disease education is provided as part of classroom instruction. It will identify where such programs exist, describe their characteristics and identify the populations they serve.

Volunteer organizations are being equipped through training with the needed tools to develop broad-based citizen participation in programs designed to eliminate venereal disease. This training effort is designed to: (1) motivate volunteer organizations and individuals to work with State and local health departments in organizing community resources and talents to focus on VD control efforts; (2) expand efforts to promote and coordinate activities of national organizations and agencies which have the potential for local impact; and (3) train leaders with emphasis on the importance of getting together at the community level with representatives of all other organizations and with representatives of media, business, health, and education to develop a coordinated attack on venereal disease.

In the past decade, venereal disease control emphasis to the private medical community has been directed solely to informing them of the program to control venereal disease, to elicit their cooperation in case reporting and in the epidemiologic process, and to provide current information on diagnosis and treatment. The current program continues to urge physicians to diagnose appropriately, treat effectively, and participate in the epidemiologic process. However, emphasis is being placed on encouraging physicians to use their influence to increase the availability of diagnostic and treatment services, to support the inclusion of venereal disease instruction in medical school curriculums, and to marshal local support and acceptance of venereal disease control efforts.

In addition to its responsibility in the implementation of national control programs, the Center for Disease Control plays an important national role in conducting and stimulating venereal disease research. The Center continues to be deeply involved with studies of disease epidemiology and control program methodologies, and with clinical and basic venereal disease research.

Research

The Center has made significant contributions to the understanding of the basic bacteriology and immunology of venereal disease. These contributions are in addition to its significant role in the quality control and production of reagents, diagnostic tests development and proficiency testing. Basic research accomplishments in past years include development of a standard selective medium for *N. gonorrhoeae* (Thayer-Martin); discovery and description of virulent Types I and II colonies of *N. gonorrhoeae* (source of gonococcal pili); measurement of *in vitro* antibiotic susceptibility of *N. gonorrhoeae* from 1950 to the present; and the development of specimen transport systems for *N. gonorrhoeae*.

Research in syphilis serology has led to the development of the FTA-ABS, FTA-IgM, and the adaptation of the microhemagglutination tests. Research bacteriologists at the Center were the first to establish both gonococcal and syphilitic infections in laboratory animals. These models are the basis for advances in the understanding of the pathogenesis and immunology of these diseases.

During FY 1973, the Center continued to stimulate interest in venereal disease research through presentations at scientific meetings of medical societies and of researchers in specialties and disciplines which touch on venereal disease, less formal presentations to ongoing physician education groups, communications with scientists to review research protocols and to stimulate young investigators to enter the field, supporting studies directed at solving specific control program problems, and by serving as a focus for research activities related to venereal disease.

Control program efforts for gonorrhea cannot succeed without the availability and utilization of effective treatment. In order to provide this necessary tool for control, the Center, through nine geographically representative areas, monitors the clinical and *in vitro* effectiveness of existing antibiotics for the treatment of gonorrhea. This effort includes: the evaluation of existing and new antibiotics, alone and in combination; the study of the mode of action, toxicity, and the development of resistance to certain antibiotics; a monitoring system to detect the emergence of resistant strains; and the development of improved assay methods for antibiotic susceptibility and blood levels. The results of these studies are analyzed by the Center and an ad hoc therapy committee, and recommendations are transmitted to State and local program areas.

In order to improve the quality of available laboratory diagnostic services for gonorrhea, a proficiency testing program has been developed and implementation has begun. This program is designed to monitor the proficiency of laboratories in States that perform gonorrhea diagnostic testing. During the initial mailout of specimens, 90% of the laboratories involved in the national screening effort participated in this program.

Realizing that expanded research in the clinical area is essential to answer the multitude of outstanding diagnostic and therapeutic questions relating to gonorrhea, the CDC coordinates a wide variety of clinical investigations, the initial and priority thrust of which is directed toward gonorrhea in the female. These ongoing studies are designed to complement efforts in basic research by providing a field laboratory for new techniques as well as a source of clinical materials for research laboratories. The Center continues its involvement in the serological screening of selected populations, serological test evaluations, therapeutic trials, investigations of the long-term effects of illness and therapy, definition of particular risk factors in host-pathogen interactions, evaluation of major control efforts, the study and improvement in clinical services and other related areas of clinical research.

Syphilis research continues to focus on cultivating *Treponema pallidum in vitro*. This accomplishment is necessary for the refinement of serologic tests, the development of a syphilis vaccine, and the expansion of knowledge about the pathogenesis of syphilis. Studies are being conducted in the growth of *T. pallidum* in a hemodialysis system, using various animal models, and in the development of a defined medium for the *in vitro* growth of *T. pallidum*.

With a marked increase in the number of anecdotes concerning positive FTA-ABS tests in patients in whom syphilis was considered unlikely and in whom none of the factors thought to be associated with "false-positive" FTA-ABS reactions could be documented, the Center has begun to define and quantitate this phenomenon.

Education

Data are rapidly accumulating to suggest that other sexually transmitted diseases are growing in importance and require further attention and definition. The three most important of these diseases are nonspecific urethritis, genital herpes, and trichomoniasis. The Center is vigorously pursuing the development of comprehensive diagnostic laboratory procedures for venereal disease diagnosis, irrespective of cause; the identification of the spectrum of agents most commonly responsible for nongonococcal urethritis; the identification of the infectious etiology of penile ulcerations; and the development of rapid diagnostic tests for herpes.

Center behavioral research efforts are directed toward studying patient responses to disease preventive measures, to public venereal disease clinics, to mass and individual education efforts, to infection and reinfection with a venereal disease, to participation in the epidemiologic and control processes, and to involvement in the venereal disease-prone population.

The steps being taken now and planned for the future will ensure the development and implementation of a fully operational national program for the control of venereal disease. In conjunction with the regional offices, national leadership and technical assistance will be provided to increase the effectiveness of venereal disease control programs by refining disease intervention techniques. Syphilis epidemiology, designed to achieve a rapid decrease in incidence through interruption of disease transmission, will continue to be a major component of this overall control strategy. Epidemiology applied to gonorrhea patients will broaden the screening net for infected females, will discover asymptomatic male as well as female cases, and will emphasize patient involvement in the entire process.

Educational efforts will continue to be directed toward communicating pertinent venereal disease facts to persons at risk, particularly youth, with the objectives of preventing exposure or reexposure to infection, and of having patients recognize the need for referral of their sexual contacts to medical care. Through educational efforts, the private medical community will be encouraged to participate in all aspects of the venereal disease control effort.

Summary

Expanded CDC research efforts will be directed to laboratory diagnostic techniques, immunology and drug susceptibility of the gonococcus. Laboratory diagnostic techniques will include, in addition to new cultural and serologic techniques, the development and improvement of media and specimen transport systems, diagnostic techniques for use by the private physician, rapid confirmatory methods of identifying *N. gonorrhoeae*, a rapid slide method of detecting soluble components of *N. gonorrhoeae*, and a method for the rapid diagnosis of gonococcal arthritis and other causes of arthritis by gas-liquid chromatography. Research in gonorrhea immunology will include colony typing systems to support epidemiologic investigations, serologic procedures, identification of virulence factors and mechanisms of pathogenicity, host responses to complicated and uncomplicated gonococcal infections, expanded animal model studies of gonorrheal immune mechanisms, and a vaccine against gonorrhea.

The Center will continue to play its role as a primary focus for operational research aimed at the practical application and evaluation of newly developed techniques in venereal disease control. With the rapidly expanding marketing of reagents, media, transport systems, packaging of products, etc., efforts will be directed toward the establishment of evaluation methodology. This evaluation will take the form of ongoing quality control procedures for currently available and new products, and a periodic dissemination of evaluation results to consumers of these diagnostic products. Efforts to evaluate newly introduced diagnostic systems will entail the following: (1) an in-house evaluation of the new system, resulting in a recommendation to proceed with a field trial; (2) a field trial at the producer's expense with CDC input into the study design, protocol and site of study; and (3) a CDC conducted field trial with careful attention to quality control of both medium and system. This evaluation scheme will be so designed that progress through these three phases will be dependent upon the merits of the new diagnostic system. Once a product has progressed through this scheme, the results and recommendations from the study would be published and disseminated. Guidelines for the implementation and use of the evaluated system will be developed and provided to State and local control programs.

National Institute of Allergy and Infectious Diseases

Gonorrhea

Gonorrhea is caused by a parasitic bacterial microorganism known as the gonococcus. The scientific name is Neisseria gonorrhoeae.

The incubation period of the gonococcus in humans is between two and eight days after exposure by sexual contact; however, symptoms sometimes may not appear until much later. In fact, 80 percent of all infected females may have no apparent symptoms of the disease. Recent studies also indicate that the prevalence of symptom-free gonorrhea in males is much higher than had been suspected and may be one reason for the current uncontrolled spread of the disease.

In males, the typical onset of gonorrhea is an acute, purulent (with pus) infection of the urethra (the canal carrying urine from the bladder). In adult females, infection of the urethra and the cervix (the entrance to the womb) is usual. In newborn children, a purulent infection of the eyes is sometimes acquired from an infected birth canal in the mother and may cause blindness unless properly treated. Complicated gonococcal infections often cause sterility, urinary obstruction, arthritis, or inflammation of a lining of the heart.

Although the gonococcus was first described in 1879, virtually nothing has been known about its basic biology. For instance, what are the best requirements for growing gonococci and differentiating them from other organisms? This information is important in isolating and transporting the organism. In many areas of the United States, laboratory facilities for diagnosing the disease are not available and clinical specimens must be shipped long distances.

Thayer-Martin medium -- the nutrient system most often used by laboratories for isolation and transport of clinical specimens -- has two drawbacks. Unusual forms of the gonococcus do not always grow in this medium and the antibiotics it contains are not always effective in preventing the overgrowth of contaminants. Both deficiencies can result in a false negative culture and misdiagnosis.

One of these drawbacks of Thayer-Martin medium has been overcome to some extent by work of a NIAID grantee, Dr. Donald Kaye at the Medical College of Pennsylvania. He developed an improved medium by substituting the antibiotic, amphotericin B, for one of the components in the medium. He found that amphotericin B inhibited the growth of Candida albicans -- a ubiquitous organism that often overgrows cultures -- without interfering with the growth of the gonococcus.

Similarly, Dr. B. Wesley Catlin, an Institute grantee at the Medical College of Wisconsin in Milwaukee, developed a new, defined medium that supports luxuriant and selective growth of the gonococcus. The medium can be used to grow organisms in 99 percent of all clinical samples.

As a follow-up, Dr. Catlin developed a unique and practical method for classifying gonococci. The technique, which is called "auxotyping", is a means of differentiating clinical strains of Neisseria gonorrhoeae based on their growth or absence of growth in each of 10 chemically defined culture media which contain or lack selected nutrients. On the basis of the patterns of gonococcal growth responses in these media, she distinguished 24 different auxotypes of gonococcus. Auxotyping is a potentially valuable tool for the epidemiologist interested in tracing the chain of infection at the community level, since, presumably, people who caught the infection from the same person would have the same auxotype.

Problems of Antibiotic Resistance. Penicillin was first used against gonorrhea in 1943 and it is still the preferred treatment. However, by 1957, physicians were reporting treatment failures with penicillin, largely due to resistant gonococci. In March 1972 the recommended dose of penicillin was raised to a new peak of 4.8 million units, a doubling of the formerly recommended concentration. Even with the new doses, there are still patients who are not cured by penicillin or who have penicillin-resistant strains of the organism.

Then, too, difficulties exist for the gonorrhea victim who is allergic to penicillin -- about two percent of the United States population. A semi-synthetic antibiotic, tetracycline, was formerly preferred for treatment of penicillin-sensitive persons. However, many tetracycline-resistant strains of gonococci have emerged and new antibiotics are being tried. Some experts estimate that 30 percent of the gonococcal isolates in this country are resistant to these "second line" antibiotics -- streptomycin, spectinomycin, kanomycin, and tetracycline. Many gonococcal strains are also resistant to multiple drugs.

Several NIAID grantees and other scientists currently are studying the mechanisms by which the gonococcal organisms develop resistance to antibiotics. A NIAID-supported investigator, Dr. P. Frederick Sparling at the University of North Carolina School of Medicine, has been studying the basis of drug resistance in the gonococcus. By working with mutants -- strains of the gonococcus whose genetic material has been altered -- Dr. Sparling found that resistance to each antibiotic is controlled by several independent, but closely linked, genes within the chromosome of the gonococci. He also found another gene, unrelated to the others, which is responsible for development of resistance to multiple drugs, including many of the antibiotics which are used to treat the disease. These findings imply that multiple antibiotic resistance may have a common genetic basis and prevention of further resistance will not necessarily be achieved by use of combinations of drugs. This work was confirmed by another NIAID grantee, Dr. Leonard Zubrzycki at Temple University School of Medicine. Continuing studies may aid scientists develop new treatments to prevent emergence of resistant strains or that will be more active against existing strains.

Dr. Sparling is also studying how altered genetic information, which confers resistance, can be transferred between the organisms. He found that transfer of genetic information takes place rapidly and efficiently when gonococci are held in close contact for 24 hours or more in test tubes. Transfer of genetic material between strains might conceivably occur by this mechanism in the human body, thus explaining how formerly nonresistant strains become resistant.

L-phase Variants. A different approach is being taken by Dr. Zell A. McGee, a NIAID grantee at Vanderbilt University Medical School. He exploits the fact that certain bacteria are not actually killed when exposed to penicillin. Instead, they merely lose their rigid, shell-like cell walls and continue to multiply as tiny, virus-sized microbes called L-phase variants. Since penicillin acts by preventing cell wall formation, it does not harm the defective variants. In fact, L-phase gonococci with defective cell walls can survive and multiply in the presence of 1000 times the concentration of penicillin that kills the usual bacterial forms. A further complication is that L-phase variants may be undetectable by routine culturing techniques.

In the first phase of his studies, the Vanderbilt scientist successfully developed a medium for growing gonococcal L-phase variants. Using this medium, he found that if gonococci formed L-phase variants which then reverted to the parent bacterial form, the reverted gonococci -- on re-exposure to penicillin -- formed L-phase variants more easily and in greater numbers than the original organism. These findings could have important implications in prescribing treatment for gonorrhea, since they imply that repeated exposure to penicillin may further increase the resistance of already resistant strains.

Another contribution to the study of antibiotic resistance comes from Dr. Catlin. Using auxotyping, she can distinguish between those patients who are truly penicillin treatment failures and those who have actually been reinfected. She found that auxotypes (strains of gonococci) repeatedly isolated from true penicillin failures are always the same before and after treatment, whereas the auxotypes may be different in patients who have been reinfected. This technique should enable physicians to treat patients more efficiently, since, frequently, patients who are actually reinfected are thought to be penicillin treatment failures and are given alternate, less effective antibiotics.

The recommended dosages of antibiotics for treating gonorrhea are now close to the maximum that can be administered on an outpatient basis. Thus, future increased drug resistance cannot be couhtered by further increases. For this reason, it would be useful if some laboratory method could be employed to determine which drug will be most efficient for each patient's gonococcal strain. Such a test was developed by Dr. Zubrzycki. The test is a variation of the "disc susceptibility technique". It involves placing various strains of gonococcus on agar plates. Then, small round discs of antibiotics are placed on the plates and where the gonococcus are killed by the drug, a clear area results, which can be measured. The size of the clear area is a reflection of the susceptibility of the gonococcus to the antibiotic in question. The test is reproducible and sensitive. Not only should it be applicable for clinical use, but it should also prove to be a useful research tool for testing gonococcal isolates for multiple antibiotic resistance.

Grouping Gonococci. The current impression among physicians and scientists is that immunity to the gonococcus is probably not acquired following natural infection, because repeated attacks of gonorrhea occur in many patients. Early and adequate treatment of gonorrhea probably interferes with the development of immunity, but even before modern antibiotics were available, repeated attacks were common.

One of the first steps in studying immunity to the gonococcus is to determine whether repeated attacks of gonorrhea are due to the same or different strain. In the past, attempts to classify the gonococcus by blood properties (serologically) have been beset by technical problems, in part, because of the biological complexity of the organism. Recently, a British scientist classified most strains of gonococcus into five serological groups. Adapting her techniques, Dr. Robert W. Quinn, a NIAID-supported researcher at Vanderbilt University School of Medicine, developed a similar, serologic test that depends upon precipitation of gonococcal antigens (those substances that induce the formation of antibodies) with specific antisera (antibodies prepared in response to specific antigens). Antibodies are the normal protective substances made by the body in response to invading organisms. Almost all of 300 strains which he has tested to date fall into nine groups. The most common group is one he designated A. It appears that the great majority of strains of gonococci recovered in Nashville during an epidemic situation belong to group A. This is similar to the situation for diseases such as polio or influenza where epidemics are usually caused by the same type of organism. Dr. Quinn also found that strains sent to him from other cities in the United States belong to group A.

This technique could be used to determine the distribution of different strains of gonococci in different cities, states, or countries. It would also be valuable in helping determine whether repeated attacks are due to same or different strains. Such studies are intimately related to vaccine development, since, if a vaccine is to be developed, scientists will have to know whether or not humans develop immunity to specific strains. Dr. McGee at Vanderbilt is collaborating in these studies with Dr. Quinn.

A different approach to the problem of typing is being taken by Dr. Ivan Goldberg at University of Kansas Medical Center. He and his colleagues are looking for bacteriophages -- viruses that usually infect and destroy only certain strains within one species of bacteria. They have improved methods for detection of bacteriophages although they have not yet found one that infects the gonococcus. They are also developing a technique to modify a bacteriophage of a related organism so that it may be able to infect the gonococcus.

The existence of a set of "typing phages" for the gonococcus would enable the investigator to easily distinguish one strain of the organism from another. A physician could use such a typing system to distinguish between treatment failures and reinfections. An epidemiologist could use the system to determine whether a strain exhibiting a very high degree of resistance to penicillin was derived from strains already present in this country or whether it was brought in from abroad.

A novel approach in typing -- that combines studies of the basic structure of the organism with an epidemiological approach -- is being taken by Dr. Emil Gotschlich at Rockefeller University. Like many bacterial organisms, the gonococcus has a cell wall consisting of two membranes. Dr. Gotschlich and his colleagues have successfully separated the two membranes and identified six proteins in the outer membrane. Of these, they found one which induces the production of antibodies. They suggest a typing system based on the major outer membrane proteins may be useful in epidemiologic studies.

Structure and virulence of gonococci. In the last three years, there has been a literal rebirth in knowledge about the structure of the gonococcus.

Gonococci are divided into four types on the basis of the way they look and grow in laboratory culture medium. Scientists had observed that of the four types of gonococci, only types 1 and 2 appeared to be "infectious" or "virulent" strains, whereas types 3 and 4 were not usually associated with disease. The reason for this difference in virulence appears to be associated with the presence or absence of submicroscopic, hair-like appendages on the surface of the gonococcus. These appendages are called "pili" and were discovered independently by a Swedish scientist and a NIAID grantee, Dr. John Swanson, now at the University of Utah Medical Center. By electron microscopy, Dr. Swanson clearly showed that pili enhance the ability of types 1 and 2 gonococci to attach to certain types of human cells. This suggested to him that pili-bearing organisms -- because they attach themselves so securely to cell walls -- can survive normal "flushing" by urine or other body secretions of the cell-lined surfaces susceptible to gonorrheal infections, such as the urethra and the uterine cervix. In contrast to these findings, Dr. Swanson was unable to find pili on the noninfectious (avirulent) strains 3 and 4.

Continuing his studies on the role of pili in causing disease, Dr. Swanson has been studying the interactions between gonococci and human leukocytes. Leukocytes are white blood cells which help protect the body against disease by engulfing and destroying foreign organisms. Dr. Swanson suspected that pilated gonococci would exhibit less attachment to and ingestion by leukocytes, since this would explain how the organisms are able to evade the defending cells and cause disease. Surprisingly, he found that pilated gonococci do not always act in the expected way, and, sometimes, nonpilated forms exhibit less attachment to leukocytes than pilated forms. He also determined that the attachment of gonococci to leukocytes is mediated by a bacterial surface substance. The significance of these findings as they relate to disease-causing properties of the organisms is under investigation.

In other experiments, Dr. Swanson discovered that the gonococci behave quite differently from other types of bacteria with regard to their interactions with leukocytes. For instance, most other bacteria -- in the presence of antibodies (the normal protective substances made by the body in response to invading organisms) -- are taken up more rapidly by leukocytes. It is the presence of such antibodies that helps confer "immunity" to a disease. Dr. Swanson found that the presence of antibodies to pili or to the whole gonococcus organism decreased the uptake of gonococci by leukocytes. These findings may be important in understanding the seeming lack of immunity of man to repeated gonococcal infection, since they imply that antibodies alone may not be sufficient to confer protection.

Screening tests. Discovery of the pili was an important step leading to the development of a promising serologic (blood) test for gonorrhea. Currently, the only reliable test for gonorrhea is an expensive, time-consuming procedure.

A new, extremely sensitive test was developed by Dr. Swanson and two other NIAID grantees, Drs. Thomas Buchanan and Emil Gotschlich of the Rockefeller University. The procedure involves analysis of a blood sample for the presence of antibodies to the pili and is called "radioimmunoassay". Using this technique, the Rockefeller University scientists examined blood samples of a great number of people and established that infection with gonorrhea does give rise to antibodies. In males with urogenital infection, the level of antibody differed somewhat from a population of normal males, but a large portion of the two populations overlapped, so that this test, in males, is extremely limited as a practical diagnostic tool.

In females, however, both those with symptomatic and asymptomatic infection, the results were more encouraging. Women with urogenital infection produced a much higher level of antibody in response to the disease and there was little overlap in antibody levels between normal and infected women. Dr. Buchanan believes the test will be particularly valuable in detecting asymptomatic women who give negative cultures. He believes that the combined use of cultures and a measurement of antibody level to the pili would significantly increase, and, perhaps even double, the present rates of detection of gonorrhea in women.

Animal models and the infectious process. A roadblock in gonorrhea research is that gonorrhea infections occur naturally only in humans. Understanding of the disease is dependent, therefore, on animal models in which the gonococcus organisms can be experimentally grown, tested, and studied.

Scientists are now a step closer to finding an ideal animal model as a result of NIAID-supported research by Drs. Buchanan and Gotschlich. Using the chick embryo as their model, they confirmed, for the first time in an animal system, the correlation that exists in human beings between types of the gonococci and their ability to cause infection.

Experimental gonorrhea infections have also been established in chimpanzees and rabbits. In the laboratory of Dr. Alvin E. Friedman-Kien, a NIAID grantee at New York University Medical Center, scientists induced a superficial infection in rabbit eyes with virulent strains types 1 and 2. This provides investigators with an experimental model for studying the infectious process in the intact animal. These studies are expected to aid in understanding the nature of the host mechanisms involved in resistance to infectious and noninfectious types of gonococcus.

Dr. Friedman-Kien also studied the effect of interferon -- a natural antiviral substance which renders cells resistant to virus infection -- on the multiplication of gonorrhea in culture systems. He is currently trying to determine if high levels of interferon can protect or treat the rabbit eye from experimental infection with gonorrhea. This model should also prove useful in evaluating the efficacy of antibiotics and other chemical substances on treating or suppressing infection with N. gonorrhoeae.

Immunity. Much remains to be learned about how man forms antibodies and develops an immune response to the gonococcus organism, if he does, in fact, develop one. Basic studies must be undertaken before vaccine development can take place. Of importance is the role that local antibodies secreted at the initial site of infection play in immunity. These antibodies are called secretory immunoglobulin A (IgA). The role of IgA in venereal infection is being studied by Dr. Alexander J. Winter, a NIAID grantee at Cornell University.

Syphilis

Syphilis is caused by Treponema pallidum, a spiral-shaped, spontaneously-moving bacterial microorganism known as a spirochete. Like gonorrhea, syphilis is acquired through sexual intercourse with a person in the infectious stage. Syphilis may also be acquired by an unborn child from an infected mother.

There are several stages of syphilis. In the primary stage, the first symptom is a small sore at the site of infection that may appear from 10 to 90 days after exposure. If the disease is not treated, a rash may develop from three to six weeks later during the secondary stage. The rash may cover the body or appear only on the hands or feet. Like the first stage of syphilis, outward signs of this secondary stage will disappear without treatment, but the spirochetes begin to invade various organs in the body.

During these first two stages, the syphilis organisms are highly infectious. If untreated, the infectious state of the disease will persist, through a stage known as early latent syphilis, for about two years from the time of initial infection. In this early latent stage, the organisms, after a long period of dormancy, begin their attack on the heart, brain, and spinal cord. Untreated syphilis can cause mental illness, blindness, heart disease, and even death.

Despite hopes that syphilis would be eradicated by antibiotics, the incidence of this infection has been increasing. Many scientists and public health officials believe that current problems with the control of syphilis stem from a lack of understanding of how the organism Treponema pallidum produces disease and from a lack of immunization procedures. In order to learn how the organism acts -- itself a necessary requirement for vaccine development -- scientists must be able to work with and study the agent outside of man, the only animal that naturally acquires syphilis. Unfortunately, the organism has proved so elusive that laboratory cultivation of it in tissue culture system has escaped researchers for the 70 years that have passed since its discovery.

Experimental syphilis studies. At work on the problem of cultivation are several NIAID grantees. One of these is Dr. Paul H. Hardy at the Johns Hopkins University. Dr. Hardy is one of the few scientists throughout the world who has maintained an interest in syphilis research -- even during the early antibiotic era when health authorities spoke confidently about eradicating the disease. Research in his laboratory has been supported for the past 16 years by the NIAID. The Hopkins group has maintained a close association with the World Health Organization and has strongly influenced treponemal research in laboratories throughout the world. Dr. Hardy's efforts include clinically-oriented studies as well as research on more fundamental problems such as cultivation of the organism.

His clinical efforts have been directed at studying congenitally-acquired syphilis in infants and young children. Using tests which detect antibodies generated by the fetus or infant, Dr. Hardy and his colleagues detected infants who were infected, then cured, via maternal treatment, while still unborn, as well as infants who escaped infection. Through these tests he was also able to monitor the efficacy of treatment.

For the past few years, Dr. Hardy and his colleagues have been examining in detail several aspects of experimentally-induced treponemal infections in animals, particularly the rabbit. His goals have been to learn how the invading spirochetes create disease in the host and how the host, in turn, can defend itself against these organisms. The knowledge gained may be valuable in developing ways to prevent or combat treponemal infections in man.

In other studies Dr. Hardy is trying to clarify the structural components of T. pallidum and related organisms. At the present time, he is working with treponemes that do not cause disease. These organisms can be cultured and thus can be studied more easily than the syphilis organism, which cannot be cultured. He is also growing T. pallidum in rabbits, "harvesting" the organisms in the purest form possible, and storing them at extremely low temperatures. Dr. Hardy hopes to apply the tissue culture procedures he is developing to the syphilis organism.

Similarly, Dr. Ercole Canale-Parola at the University of Massachusetts is studying spirochetes which are related to the syphilis organism. He has concentrated on two common treponemes that inhabit the human body, without causing disease.

For example, he investigated growth requirements of Treponema denticola, found in the human mouth. His studies revealed the nutritional requirements of the organism and provided an explanation of how the organism is able to live in the host. He also developed a procedure for isolating spirochetes found in the human intestine which may be applicable to development of culture techniques for T. pallidum.

Immunity and Vaccine Development. The prevention of syphilis infection by development of a vaccine is an extremely complex problem because the mechanisms of immunity -- the way in which the host protects itself against invading organisms -- are still not clearly understood. This is another area of research that has received renewed stimulus as a result of NIAID's special emphasis grant program in venereal diseases.

Not much has been known about the role that antibodies and cells play in the defense mechanisms against syphilis. Basically, the human body has two types of immunity: humoral immunity, which depends on antibodies that circulate in the bloodstream and are activated against foreign materials, and cellular immunity, which utilizes various types of protective cells that can be mobilized to destroy foreign materials. In syphilis, infection progresses through the primary and secondary stages despite the presence of large amounts of circulating antibody to the treponemal organism. This implies that the cellular immune system plays an important role in disease protection.

Studies aimed at elucidating, in syphilis, these two defense mechanisms have been underway at Johns Hopkins by Dr. Hardy. He found that antibodies can modify the early clinical disease in rabbits by prolonging the incubation period before the appearance of initial sores and by modifying the lesions that develop. However, he could not produce complete protection against disease by administration of antibodies. In contrast, in a different experiment, he found that development of a strong cellular response is advantageous to the host.

Drs. Daniel Musher and Konrad Wicher, NIAID grantees at Baylor College of Medicine, Houston, and the E. J. Meyer Memorial Hospital, Buffalo, N.Y., respectively, are also studying the role of cellular immunity in protection against syphilis. Using rabbits, they are able to manipulate the white blood cells of the host and study the effect of the organisms in causing disease. These studies not only have application to vaccine development, but also possibly to development of an improved diagnostic test for syphilis -- one in which cells that have responded to the organism could be identified.

Structure of Organisms. In a different approach, NIAID grantee Dr. Russell C. Johnson at the University of Minnesota is studying the structure of treponemes in an attempt to define the role that various components of the organism might play in triggering immunity. Dr. Johnson developed a simple method for separating the outer covering or envelope of these nonpathogenic treponemes and showed that the envelope preparation induced the formation of antibodies in rabbits.

When he began the study, Dr. Johnson was not certain that the syphilis organism also possessed an outer envelope. Using the electron microscope, he was able to photograph this structure in T. pallidum. He also demonstrated that the outer envelope of a similar disease-causing spirochete, Leptospira, contains antigens which stimulate protective antibodies. Animals which he vaccinated with outer envelope preparations from Leptospira were protected from a subsequent exposure to the organisms. If the technique can be applied to the syphilis organism and if the purified outer envelope of that organism induces protective immunity, progress will have been made toward development of a vaccine.

Another grantee, Dr. Sally Jackson at Baylor College of Medicine in Houston, is trying to isolate chemical substances in the surface layers of T. pallidum, which may be responsible for its ability to cause disease. Other bacteria, such as the common intestinal bacteria Escherichia coli, contain such chemicals, called lipopolysaccharides (LPS). Dr. Jackson identified and isolated a substance from T. pallidum that resembles LPS from other organisms. Further studies on the nature of this substance should increase understanding of the mechanism by which these organisms cause disease.

Other Venereal Diseases

Most people tend to think of syphilis and gonorrhea as the only venereal diseases. In fact, there are other infections that are transmitted by sexual intercourse.

One of the most prevalent of these infections -- perhaps even more common than gonorrhea -- is herpes virus type 2 infections. Herpes virus type 2 belongs to the family of viruses that causes typical cold sores and fever blisters. The infection is not as serious as gonorrhea or syphilis in that it does not lead to the chronic pain, chronic disability, and infertility associated with gonorrhea, nor does it lead to the many fearful manifestations of late syphilis. However, herpes virus infection of the female genital region does have major importance because it is the cause of disseminated herpes virus infection of the newborn -- frequently a fatal disease -- and also because genital herpes virus infection may be linked to development of cervical cancer. The National Cancer Institute is currently investigating the relationship of herpes infection to cervical and other types of cancer.

Herpes infections produce acute pain and temporary disability and, unfortunately, as in all viral infections, there is no specific cure. For this reason, the Infectious Disease Branch of NIAID is supporting two contractors who are studying the effect of antiviral chemicals on herpes infections in mice. If this treatment works in mice, the findings may be applicable to treatment of the disease in man.

Other significant venereal diseases being studied by NIAID grantees include nongonococcal venereal urethritis, chlamydial infections, and trachoma inclusion conjunctivitis (TRIC) infections.

Nonspecific urethritis is probably one of the most common sexually transmitted diseases although it is not a reportable disease like gonorrhea. Studies are underway by NIAID grantee Dr. William McCormack of Boston City Hospital to determine the cause of this disease.

Dr. Julius Schacter of the University of California, San Francisco, is studying venereally transmitted disease caused by TRIC infections. By surveying more than 2000 patients, he determined that one in four men and one in six women seeking medical attention for genital tract infections had infections caused by a TRIC agent. Non-symptomatic women have a carrier rate of about five percent for TRIC cervical infection. These studies are aimed at determining the extent of the public health hazard posed by these infections.

Outlook

Although new knowledge is being collected under the NIAID grantee and contract programs, much remains to be learned before medical science can offer hope for effective ways to prevent gonorrhea and syphilis. Before the discovery of penicillin, research techniques were not sufficiently sophisticated to permit many of the fundamental studies which are now being supported by NIAID. These NIAID research efforts should contribute to a reversal of the present epidemic and to a general reduction in venereal disease.

THE SUDDEN INFANT DEATH SYNDROME

In the United States, the sudden infant death syndrome (SIDS), also known as crib death, is the leading cause of death among infants between the first and twelfth months of life. It is estimated that about three infants per 1,000 live births succumb to this syndrome. Most victims are between the ages of one and six months. The frequency is highest between the second and fourth months of life.

The National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health has primary Federal responsibility for research on the sudden infant death syndrome. Other Federal programs related to SIDS involve the National Institute of Neurological Diseases and Stroke (NINDS) of the National Institutes of Health, the National Center for Health Statistics of the Health Resources Administration, and the Bureau of Community Health Services, Maternal and Child Health of the Health Services Administration.

Obligations for programs in Sudden Infant Death Syndrome

	1971	1972	1973	1974 estimate	1975 estimate
National Institutes of Health:					
National Institute of Child Health and Human Development......	$1,800,000	$3,550,000	$4,106,000	$4,700,000 *($5,000,000)	$4,700,000
Health Resources Administration:					
National Center for Health Statistics......	---	---	11,000	---	---
Health Services Administration:					
Bureau of Community Health Services:					
Maternal and Child Health.................	---	35,000	---	---	---
Total...............	1,800,000	3,585,000	4,117,000	4,700,000	4,700,000

*1974 figures in parentheses represents 1974 base figures plus 1973 restoration.

NATIONAL INSTITUTES OF HEALTH

National Institute of Child Health and Human Development

Crib death strikes without warning. In the majority of cases the baby is apparently in good health and feeds without difficulty. While there may be evidence of a slight cold or stuffy nose, there is no history of serious upper respiratory infection. The infant is placed in his or her crib for a nap or for the night and several hours later is found dead. Following autopsy, no cause of death can be identified.

The sudden infant death syndrome (SIDS) is a world-wide health problem. It occurs more frequently in males than in females, in non-white than in white babies, in families of lower socioeconomic status, in premature infants, particularly those who had gestational ages between 34 and 35 weeks, and in babies who had recent infections. Twins may be especially vulnerable to SIDS. It is likely that this tendency is related to their typical lower birth weight or shortened gestational period.

Most crib deaths in the United States occur in the cold weather between November and March. Sudden changes in temperature may trigger the syndrome. The risk appears to be highest in crowded environments. Autopsies show a high incidence of minute hemorrhages within the chest in victims who are otherwise free of abnormal tissue changes. This may be due to a short, but silent, terminal struggle to breathe.

Why these babies die is unknown. Many reasons have been offered to explain the deaths, including neurophysiologic, immunologic, cardiorespiratory, endocrine, and infectious disease causes. None to date has explained it correctly. All factors believed to be associated with the syndrome appear to be intertwined. It is not known, however, which one of the associations is most important.

Research Objectives in SIDS

Beginning in April 1971, NICHD intensified its research on the sudden infant death syndrome. The objectives of this expanded effort are:

1. To increase understanding of underlying mechanisms of the syndrome.
2. To discover its probable cause or causes.
3. To identify infants at risk of becoming victims.
4. To explore preventive approaches.
5. To stimulate scientists to direct investigative efforts toward solution of this complex problem.
6. To elucidate the impact of a sudden and unexpected infant death on the subsequent behavior of parents, siblings and the extended family.

7. To learn more about the management of SIDS cases in the United States and to develop guidelines for coroners, medical examiners, and pathologists in handling these cases.

8. To provide training of scientists with interests in neurophysiology, cardio-respiratory physiology, metabolic and thermoregulatory processes, epidemiology, pathology, immunology, infectious disease and social psychology related to the syndrome.

9. To support interdisciplinary conferences and workshops.

10. To prepare and distribute scientific publications and public information materials.

Seven Emphasis Areas in SIDS Research

The NICHD has developed its SIDS research around seven emphasis areas:

1. Abnormal sleep patterns related to breathing and circulation and other functions essential to life.

2. Respiratory, cardiac, and circulatory responses to such stimuli as excess carbon dioxide in the blood or oxygen deficiency, which may make some babies likely to die.

3. The body's system for temperature regulation and its response to environmental conditions existing at the time of death.

4. The baby's developing immune system and how defects in development may predispose an infant to the syndrome.

5. The distribution of the sudden infant death syndrome within the population and characteristics surrounding its occurrence in order to identify infants at high risk and to determine its causes.

6. Studies of the structural and functional changes in tissues and organs which may be involved.

7. The psychological stresses experienced by the family and the community when a sudden and unexplained infant death occurs.

The NICHD has sponsored a series of planning workshops to consider the nature and scope of this problem, identify new approaches, and highlight specific research questions in need of in-depth study. These workshops bring together investigators with expertise in areas having direct relation to the syndrome. The workshops have been beneficial in expanding the horizons of knowledge and have attracted qualified scientists to work on the problem of SIDS. Four workshops were held in 1972, four in 1973, and three planned for 1974. A summary report of each workshop is published.

Specific Research Projects

In FY 1973 the NICHD provided support for 72 research projects aimed at understanding the syndrome. This included 11 grants and contracts specifically concerned with SIDS and 61 for pertinent related studies. FY 1973 support approximated $4.1 million compared with $3.5 million in FY 1972. Funding for FY 1974 is estimated at approximately $4.7 million.

The Institute's expanded research on the syndrome and staff consultations have stimulated numerous inquiries and grant applications. In FY 1973, 21 grant applications directly related to SIDS were reviewed by the National Advisory Child Health and Human Development Council. Seven were recommended for approval; five have been funded. Institute staff members have communicated with all applicants whose proposals were not approved or will not be funded, in an effort to help them improve their applications.

In several of the workshops, the importance of finding animal models suitable for research was stressed and deemed essential to an understanding of underlying mechanisms. To implement this recommendation, the Institute solicited proposals and negotiated two contracts aimed at developing animal model systems for research.

Contract Studies

One contract calls for a broad approach including the relationship of genetics, infectious disease, immunologic and epidemiologic factors to onset of naturally occurring sudden and unexplained death in kittens. The other contract involves study of how the larynx and its nervous control may relate to the arrest of breathing in fetal and newborn lambs and kittens. The investigators are particularly concerned with effects of fluids such as water (with and and without sugar) and milk on closure of the upper airway.

In June 1972, the Institute contracted with Children's Orthopedic Hospital in Seattle, Washington to survey current management of sudden infant death cases in a sample of standard metropolitan statistical areas in the United States.

Among the findings from this survey are that: 1) there was a considerable lack of knowledge about crib death among public health and safety officials, which often resulted in a lack of sensitivity to the needs of bereaved parents; 2) there was a positive correlation between knowledge about crib death on the part of officials involved in SIDS and the degree of supportive management demonstrated in the handling of these cases; 3) poorer people were more likely to be handled with a lack of understanding than others; and, 4) some medical examiners had been quite sensitive to the needs of bereaved parents so that the impact of SIDS deaths was lessened.

The results have emphasized need for broad distribution of information about crib death to medical examiners, public safety officials, hospital emergency room personnel, pediatricians, nursing personnel, and parents. The Institute is now preparing a document to achieve this, which will be available during FY 1974.

New Leads

New leads evolving from NICHD-supported activities include:

1. SIDS May be Related to Heart Rate Changes, Apnea, and Infection. All infants demonstrate breathing irregularities during their normal sleep. A scientist at the State University of New York at Syracuse showed that some infants have prolonged halts in breathing (apnea) during transition into rapid eye movement (REM) sleep--a particular period of "active" sleep which normally occurs several times during a sleep cycle. Furthermore, this investigator found a relationship between apnea episodes and changes in heart rate, and that infections in the upper airways appear to increase the sleep-related episodes of prolonged apnea and associated slowing of heart rate.

2. SIDS May be Related to Lack of Sleep. An investigator at the School of Medicine of the University of California at Los Angeles is studying the relationship of these temporary halts of breathing to patterns of sleep in kittens. An important observation is his finding that the frequency of apnea was greatly increased following prolonged periods of lack of sleep. The ability of a kitten to wake itself during a period of apnea was also reduced during REM sleep and following sleep deprivation. Moreover, spontaneous spasms in the larynx were frequent during REM sleep.

These observations are important because a prolonged apneic period occurring at a time when arousal mechanisms are suppressed could lead to a lack of oxygen in the tissues and central nervous system depression. Such depression could result in sudden death without pathologic findings. It is also possible that a laryngeal spasm occurring at a time when waking up mechanisms are depressed could precipitate death.

3. SIDS Babies May Lack Oxygen. Another investigator, at the Hershey Medical Center of Pennsylvania State University, has demonstrated enlargement and abnormal growth of smooth muscle fibers in small arteries of the lung area of babies who had died from SIDS. The findings suggest that these infants experienced long-term lack of oxygen in the lung, since such an increase is known to be associated with oxygen lack.

4. SIDS May be Related to an Abnormality in the Brain Stem. A scientist at the Montefiore Hospital and Medical Center, New York, has proposed that an abnormality in a part of the lower brain stem which is involved in control of normal breathing may cause disruption of the breathing cycle, leading to apnea during sleep. Investigators propose to test this hypothesis by studying breathing patterns and electroencephalograms (EEG's), in a group of SIDS "near misses"--infants who stopped breathing and required resuscitative efforts for survival. These babies are thought to be potential victims of the sudden infant death syndrome.

5. SIDS May be Related to Immaturity of the Nervous Mechanism Controlling Heart Function. A group of scientists at University of Southern California believe that there may be a relationship between SIDS and immaturity of the mechanisms controlling heart function. They have found by looking at records of babies who later died of SIDS that the babies had a tendency toward high levels of carbon dioxide in their systems and certain abnormalities in heart function during and just after delivery. These studies suggest that immaturity of the nervous system controlling the heart might be identified by monitoring fetal heart rate during labor.

6. SIDS May be Associated With Obstruction Due to Viruses in the Blood Supply of Lung Area. A pathologist at the University of Tennessee, using several methods, will look for evidence of viruses at autopsy of SIDS victims. He will also determine the concentration of oxygen in the blood in the left side of the heart (left ventricle) in order to ascertain whether the babies died primarily from respiratory failure. Individuals with pulmonary death tend to have low oxygen concentrations in the left side for many hours after death while patients who die from other causes have higher oxygen levels in the left side.

7. SIDS May Result from Inadequate Lung Responses. A scientist at the Hospital for Sick Children in Toronto, Canada will study the hypothesis that some infants' lungs cannot respond to stress on their respiratory system and that this might contribute to the occurrence of SIDS

NICHD Information Program

The National Institute of Child Health and Human Development is continually expanding the availability of publications for distribution to the scientific and lay communities as part of its sudden infant death syndrome information program. Publications currently in print include:

Summary of Proceedings: Second International Conference on Causes of Sudden Infant Death Syndrome, Seattle, 1969

SIDS: Selected Annotated Bibliography, 1960-1971

Research Planning Workshop on The Sudden Infant Death Syndrome

SIDS Research Planning Workshop: Developmental Aspects of Infection and Immunology

SIDS Research Planning Workshop: Neurophysiological Factors

Facts About Sudden Infant Death Syndrome

Publications currently in preparation for distribution in FY 1974 include:

SIDS: A Family Crisis

SIDS: Information for Parents and Rescue Workers

SIDS: Management of Cases in the United States

SIDS Research Planning Workshop: Cardiorespiratory Phenomena

SIDS Research Planning Workshop: Behavioral Considerations

SIDS Research Planning Workshop: Epidemiology

SIDS Research Planning Workshop: Pathology

The NICHD has convened an HEW Interdepartmental Committee on Federal Efforts in the Sudden Infant Death Syndrome. This group meets quarterly to discuss SIDS activities of each program and progress being made by each group. The Committee was established to enhance communication, to keep all involved groups informed of ongoing Federal activities in SIDS, and to identify new approaches as warranted.

In addition to NICHD staff, there is representation from NINDS, NIMH, Bureau of Community Health Services, Health Services Administration, and the National Center for Health Statistics, Health Resources Administration. Plans are under way to include representation from other related and interested federal programs.

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

The Health Resources Administration (HRA), National Center for Health Statistics, is also supporting some work in SIDS. As a result of work with the World Health Organization, the coding of SIDS deaths has changed beginning with the 1973 data year. Now all SIDS deaths will receive the same ICDA (International Classification of Diseases Adapted), code (795.0), whereas previously they had been coded to four different categories along with non-SIDS deaths.

In addition, all mention of SIDS will now be coded, even those occurrences which have specific diseases mentioned along with them. This will enable more accurate counts to be made of the number of death certificates which mention SIDS, thus greatly facilitating research on SIDS.

NATIONAL INSTITUTES OF HEALTH

The National Institute of Neurological Diseases and Stroke

Because of valuable data already available, the National Institute of Neurological Diseases and Stroke (NINDS) has negotiated a contract related to SIDS with the University of Pennsylvania. The Collaborative Study on Cerebral Palsy, Mental Retardation and Other Neurological Diseases of Infancy and Childhood, a prospective study which has monitored events, conditions and abnormalities of 50,000 women during their pregnancies, included an analysis of an estimated 75-100 cases of the sudden infant death syndrome. The contracting university will assess the data on the women, their pregnancies, and their offspring who became victims of SIDS, and compare them with a set of matched controls.

HEALTH SERVICES ADMINISTRATION

Bureau of Community Health Services, Maternal and Child Health

The principal activities of Maternal and Child Health (MCH) in the sudden infant death syndrome have been to produce a training film and to conduct a series of regional conferences for professional and community health workers.

The training film, "One in Three Hundred and Fifty" was produced with a $30,000 MCH grant made to Dr. Abraham Bergman at Children's Orthopedic Hospital in Seattle, Washington. This 16mm. black and white 25-minute film is a documentary in which four sets of parents discuss their experiences following a sudden and unexplained infant death. The purpose is to introduce an awareness of the problem of SIDS and to learn more effective ways to assist families following such a loss. Four copies of this film will soon be available on a rental basis through the Foundation for Sudden Infant Death, New York City.

Children's Orthopedic Hospital in Seattle was awarded a second grant of $9,800 for a series of regional conferences on the sudden infant death syndrome, to run from July 1, 1972 through June 30, 1974. Eleven conferences are planned for this period.

The largest group of participants at conferences were nurses employed in public health, pediatrics, and emergency services. State and regional consultants in maternal and child health participated in large numbers. Physicians, social workers, clergymen, lawyers, psychologists, law enforcement officers, coroners and medical examiners have also attended.

A typical conference includes opening sessions during which participants learn about the incidence and origins of the syndrome. Discussion by a panel of parents who have experienced a loss or showing of the movie "One in Three Hundred and Fifty" precede consideration of the psychological impact of such an event and its aftermath. The second segment of the program is a discussion of specific topics with participants in smaller groups. Qualified group leaders and participants discuss the impact of a sudden infant death on siblings and relatives, distinctions between SIDS and child abuse, the process of grief and mourning, "red tape" following such a death, the need for parental support and counseling, assistance to parents after the birth of subsequent children, and organization of community agencies to provide necessary services to parents following the loss of an infant. The conferences generally close with consideration of future research, education and services that are needed.

The effect of these conferences, plus the continued distribution of teaching materials through the regional MCH program staff to the MCH staffs in State Departments of Health, MCH Special Projects and institutions of higher learning, is becoming more evident. In some states such as Arizona, MCH formula funds are being used to support statewide services. Nursing consultants in the State Department of Health of Colorado have been providing direct counseling and follow-up to parents in remote areas.

In Montana, the state MCH staff conducted a two-part SIDS in-service (March and June 1973) for public health and hospital nurses. The Kansas State Health Department nurses had a similar in-services program for clinical specialists counseling families in well-child conferences, family planning settings and MCH projects. At a meeting of MCH nursing consultants and clinical specialists, in Denver, a paper on SIDS was presented to stimulate interest and encourage participation in local area programs

It should also be noted that there is greater inclusion of material on SIDS in university programs. The syndrome has been presented in "pediatric grand rounds" at the University of Colorado and in Boston. Nursing schools are finding more student interest expressed in this syndrome. In addition, SIDS has become a part of the study of the broader area of death, grief and mourning of parents who lose an infant or child from any condition.

SICKLE CELL ANEMIA

Sickle cell anemia is a hereditary blood disease found preponderantly, but not exclusively, in black people. It afflicts an estimated 50,000-60,000 Americans. These persons suffer from chronic blood deficiency and are subject to painful, frequently disabling episodes called sickle cell crises. The disease may also result in jaundice, increased susceptibility to infections, retarded growth, and shortened life expectancy.

Sickle cell anemia occurs only when the child inherits from each parent a gene for producing an abnormal form of hemoglobin, the oxygen-carrying pigment of red blood cells. Under certain conditions, such as reduced blood oxygen levels or increased blood acidity, the abnormal pigment, called sickle hemoglobin, may aggregate to form long rods that force the red blood cells into rigid crescent or sickle shapes whence the disease derives its name. Sickled cells do not flow readily through the smaller blood vessels and may plug them, impeding bloodflow to various organs and tissues and thereby causing many of the complications of the disease.

An additional two million Americans have sickle cell trait. They carry one gene for sickle hemoglobin, but also one for normal hemoglobin, which predominates in their red blood cells. Sickle cell trait rarely causes health problems, but carriers can transmit the gene to their children. If two carriers of the trait marry, the odds are two in four that a child born of this marriage will have sickle cell trait, one in four that the child will have completely normal hemoglobin, and one in four that the child will have sickle cell anemia.

There is presently no cure for sickle cell anemia, although supportive treatment continues to improve and measures to reduce the threat of sickle cell crises and other complications of the disease are being more widely applied. Also under study are "antisickling" agents which hold promise for reducing the frequency of crisis episodes and decreasing the attendant tissue damage and subsequent complications.

The National Sickle Cell Disease Program is a cooperative endeavor involving NIH, the Health Services Administration and other federal and private agencies. The chief NIH participants are National Heart and Lung Institute, which is charged with overall coordination of the National Program; National Institute of Arthritis, Metabolism, and Digestive Diseases; and National Institute of General Medical Sciences. The Program also cooperates with other federal agencies concerned with various aspects of the sickle cell disease problem, including the Department of Defense, the Veterans Administration, and the Department of Labor.

Obligations for Programs in Sickle Cell Disease

	1971	1972	1973	1974 Estimate	1975 Estimate
National Institutes of Health:					
National Heart and Lung Institute......	$935,000	$10,192,000	$15,320,000	$16,000,000	$16,000,000
National Institute of Arthritis, Metabolism and Digestisve Diseases.	855,000	964,000	1,120,000	1,116,000	1,154,000
National Institute of General Medical Sciences............	100,000	100,000	100,000	100,000	100,000
Total, National Institutes of Health...	1,890,000	11,256,000	16,540,000	17,216,000	17,254,000

NATIONAL INSTITUTES OF HEALTH

National Heart and Lung Institute

In his 1971 Health Message to the Congress, President Nixon identified sickle cell anemia as a high priority disease target and called for increased federal expenditures for research directed against this disorder. Subsequently, a Sickle Cell Disease Advisory Committee was named by the Secretary of Health, Education, and Welfare to provide advice and assistance in planning and carrying out this expanded effort.

In May 1972, the National Sickle Cell Anemia Control Act established a national program of research, training, information, and community service activities dealing with sickle cell anemia. Specifically, the Act provides for

- establishment of screening and counseling programs;
- establishment of information and education programs;
- grants and contracts for research and development activities for diagnosis, treatment, and control of sickle cell anemia, together with training in these areas;
- screening, counseling, and treatment in Public Health Service facilities; and
- encouragement of participation in these activities by voluntary health agencies and other non-federal groups.

National Institutes of Health was designated the lead agency in the Program, with the Chief of the NHLI Sickle Cell Disease Branch serving as coordinator. Funds earmarked for the National Program are located in the NHLI appropriation.

First awards under the Program were made in July 1972. They provided $9 million in support of Sickle Cell Disease Centers, Screening and Education Clinics, and research projects. Obligations for grants and contracts during Fiscal Year 1973 have totalled $14.5 million. Principal elements of the Program are described below.

Comprehensive Sickle Cell Disease Centers. Five new centers were established during 1973 and support was continued for ten others established the previous year. Organized around ongoing sickle cell anemia efforts, these centers coordinate research and community-service projects.

Research activities include studies on sickle hemoglobin; the nature of the sickling phenomenon and the factors and cofactors that trigger it; the role of blood coagulation factors in sickle cell crises and the clotting complications that often attend them. Also under study are changes in the red-cell membrane during sickling, the effects of various agents on the sickling process, and the immunological impairment that increases susceptibility to infection in persons with sickle cell disease.

Community service activities have centered on development and testing of 1) information and educational materials about sickle cell disease for the public, 2) counseling approaches and techniques, and 3) vocational rehabilitation procedures.

Screening and Education Clinics. Eleven new clinics were established during 1973, bringing the total supported to 26. These clinics are concerned with 1) improved methods of distributing information on sickle cell anemia and sickle cell trait, particularly to populations at risk; 2) screening and counseling services; and 3) helping people with sickle cell anemia find and use available medical facilities and related services.

Mission-Oriented Research and Development Projects. The 28 projects supported during 1973 encompass a number of research areas, all concerned with improved methods of prevention, diagnosis, treatment, and, especially, the clinical management of sickle cell crises.

The National Heart and Lung Institute and components of the Health Services Administration are engaged in targeted research, field studies, and genetic screening and counseling in sickle cell anemia. The National Institute of Arthritis, Metabolism, and Digestive Diseases had engaged in research and research support in sickle cell anemia prior to organization of the above special program; and, because of its previous productivity, this research is continuing.

An NIAMDD grant-supported researcher, Dr. John R. Murphy of Case Western Reserve University, Cleveland, Ohio, has shown that the sickle cell trait among black National Football League players (6.7%) differs little from that of the general black U.S. population (7.7%) and, thus, is clearly no barrier to participation and excellence in one of the most rigorous and demanding of professional sports.

This is also an indication that there is no need for any selective exclusion of such individuals from other, less physically demanding activities, and supports a recent evaluation by the National Academy of Sciences-National Research Council of the status of sickle cell trait carriers in the Armed Forces. The latter study recommended that there be no limitation on activity except for pilots and co-pilots, who may suffer sickle cell crises following exposure to low oxygen tension in inspired air at high altitudes in nonpressurized planes.

NIAMDD grantee Dr. Michael D. Garrick, of the State University of New York, Buffalo, has devised a simple, practical and inexpensive method for detecting sickle-cell disease and other hemoglobin abnormalities. It utilizes dried blood specimens on filter-paper, such as that used in mass screening of newborn infants for phenylketonuria (PKU) in many states and foreign countries. This convenient and inexpensive procedure has now been adapted for sickle cell disease and other hemoglobinopathies at a cost of only 3 cents per specimen, and it permits screening of 250-500 specimens per day.

During sickle cell crises, large numbers of sickled cells jam the smaller blood vessels and impede bloodflow to various organs and tissues, especially the spleen, liver, intestine, and joints. The crises cause severe pain, frequently disable the victim for several days or more, and may cause permanent damage to affected tissues. Crises may be precipitated by heavy exertion, infections, exposure to cold, dehydration, or other factors that decrease blood oxygen levels or increase blood acidity.

A two year clinical trial, recently completed at six participating institutions, evaluated and compared three promising forms of treatment for sickle cell crisis. These were

- Infusions of urea in invert sugar solution. Laboratory studies had shown that urea could dissipate the bonds holding sickle-hemoglobin in the rod-shaped aggregations that cause sickling. Some scientists had concluded, from limited clinical studies, that urea promoted the "unsickling" of red cells during sickle cell crises in patients, thereby reducing the duration and/or severity of the episode.

- Infusions of alkali (sodium bicarbonate or lactate) to correct the excess blood acidity believed to be a precipitating factor in sickle cell crises.

- Infusions of dextrose or invert sugar in normal saline to correct dehydration, another precipitating factor in sickle cell crises.

Urea performed no better than did the other, more conventional treatments in this trial. The results of each treatment were less than satisfactory. Urea thus offers no clear-cut clinical advantages that offset its drawbacks: the agent can cause vein irritation, especially in higher concentrations; and large doses also produce massive diuresis that upsets fluid and electrolyte balance unless these are closely monitored during treatment.

Another anti-sickling agent, cyanate, is being studied to ascertain its mode of action, toxicity, and potential for clinical use, but is not yet considered ready for large-scale clinical trials.

The therapeutic use of cyanate in sickle cell disease is under study by Dr. George Stamatoyannopoulos with support from a National Institute of General Medical Sciences genetics center grant to Dr. Arno Motulsky at the University of Washington, Seattle. While cyante has shown promise in inhibiting sickling and prevention of sickle cell crises, it is known to cause changes in the properties of various enzymes in mice, including those of the brain. Its long-term clinical use might therefore cause undesirable side effects. Working experimentally with monkeys the past year, Dr. Stamatoyannopoulos devised a novel system of extra-corporeal cyanate administration and dialysis which is similar in principle but simpler than artificial kidney treatments. Essentially, the blood is shunted outside the body, treated with cyanate and returned after the excess, unreacted cyanate has been removed by dialysis. As a result of such treatment, the alteration of non-blood proteins and presumably damaging side effects can be prevented. Accordingly, it appears that the method eventually may open the way to safer treatment of patients with cyanate and perhaps other new anti-sickling drugs.

The original observation of cyanate's anti-sickling properties by Drs. Anthony Cerami and James M. Manning was made under the grant from NIGMS to Drs. Stanford Moore and William H. Stein of the Rockefeller University.

The NIGMS also funds a number of additional studies on the structure and function of hemoglobin and various other hemoglobinopathies which, while not focused directly on SCA may well contribute new understanding highly applicable to its management and control.

Other mission-oriented projects are concerned with developing safe, reliable techniques for the prenatal diagnosis of sickle cell anemia and other hereditary blood diseases. The study of blood samples drawn from the fetus or of fetal blood cells from the amniotic fluid is the basis of present approaches to the problem. Evaluation of laboratory techniques for sickle cell disease is also underway in an attempt to find more accurate, less expensive, faster and automated means of detecting abnormal hemoglobins in early infancy and later life.

Biomedical Research Project Grants. Forty-two regular research grants were awarded during Fiscal Year 1973. These grants supported both basic and applied research into the nature, cause, diagnosis and treatment of sickle cell anemia. Areas of study include:

- development of animal models of sickle cell anemia.
- evaluation of the metabolism of red blood cells; studies of the structure and permeability of the red-cell membrane; and physical and biochemical changes that occur with sickling and their effects on red-cell survival and on flow characteristics in the smallest blood vessels.
- the effects of various bodily substances, drugs, and other agents on sickle hemoglobin and on the rate of sickling or unsickling of red cells.

Information and Education Program. The NHLI Sickle Cell Disease Branch coordinates the acquisition, development, publication, and distribution of educational information on sickle cell disease to health professionals and to the public. The Health Services Administration and other federal and private agencies are also actively involved in information activities, as are Screening and Education Clinics and other elements of the National Program.

Education. Continuing education programs are being carried out by a number of Comprehensive Sickle Cell Disease Centers and by other federal and private organizations. The Hemoglobinopathy Laboratory of the Center for Disease Control is training personnel in techniques for identifying sickle-cell hemoglobin and other abnormal variants. It is also providing proficiency testing services for personnel from Centers, Screening and Evaluation Clinics and state and private laboratories.

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Sickle Cell Anemia

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary of HEW to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

Nearly 200,000 copies of a cartoon coloring book on sickle cell anemia have been distributed by the Office of Child Development since August 1972. Created for the Office of Child Development, the cartoon story book, "Where's Herbie?" describes the origin, symptoms and treatment of sickle cell disease. The Office of Child Development's primary contribution to the sickle cell campaign has been to create public awareness of the disease through health education. In addition, staff members in Head Start, Home Start, Parent and Child Centers, and Child and Family Resource Programs inform parents of sickle cell screening available under the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program (Title XIX). Testing is conducted when appropriate.

LEAD-BASED PAINT POISONING

Obligations

	1971	1972	1973	1974 estimate	1975 estimate
Public Health Service:					
Center for Disease Control..........	$158,000	$7,546,000	$7,805,000	$11,755,000 2/	$7,341,000
Health Services Administration....	1/	1/	1/	1/	1/
Office of Human Development.........	1/	1/	1/	1/	1/
Total............	158,000	7,546,000	7,805,000	11,755,000 2/	7,341,000

The potential for lead poisoning exists wherever lead-based paint is accessible to children, especially in deteriorating housing where peeling paint and paint chips are found. There are an estimated 2.5 million children in the United States between the ages of one and six years who are living in dilapidated housing with interior surfaces containing lead paint.

Of the children with elevated blood-lead levels many may have lead poisoning and others may suffer neurological handicaps including mental retardation. Control of childhood lead poisoning is based on identification and medical follow-up of children with elevated blood-lead levels and the reduction or elimination of lead-based paints hazards in their housing environments.

1/ Obligations not identifiable.
2/ Includes $4,500,000 of FY 1973 funds restored in FY 1974.

CENTER FOR DISEASE CONTROL

The Environmental Health Services Division within the Bureau of State Services is continuing the program to prevent childhood lead poisoning which was initiated by the former Bureau of Community Environmental Management. Since late in FY 1972, project grants have been awarded to communities to screen children for undue lead absorption as disclosed by elevated blood lead levels. The primary purpose of the grant program is to assist communities in preventing lead-based paint poisoning through an intensive program of early detection. These grants strengthen community efforts of treatment and hazard reduction by providing a system for identifying individual children in need of medical care, and for identifying specific premises which must receive priority hazard reduction attention. The prevention-oriented outreach effort is particularly important since the serious sequelae of lead poisoning are irreversible.

During FY 1973, over 275,000 children were screened in 40 project communities. Programs were initiated late in the year in two additional communities. Of the 275,000 children tested, approximately 10 percent were found on initial testing to have blood lead levels exceeding 40 ug per 100 milliliters of whole blood--the generally accepted level suggesting undue lead absorption. Of these, approximately 4,600 required treatment. Approximately 25,000 dwelling units were inspected as a result of these screening results, and hazard reduction actions were documented in 9,300 of these. It is anticipated that a minimum of 300,000 children will be tested in FY 1974 and in FY 1975 through these community projects. The Center for Disease Control will continue the policy of cooperating with other Federal agencies who have interests and responsibilities in areas related to childhood lead poisoning, such as Maternal and Child Health programs, the activities of the Department of Housing and Urban Development, Children and Youth projects, Mental Retardation programs, and the Early Periodic Screening, Diagnosis and Treatment programs under Medicaid. During FY 1974 and 1975, emphasis will be placed on developing the necessary laboratory competence in lead analysis in States and communities which have not yet put this emerging technology to work, this activity will be funded from FY 1973 funds restored in FY 1974. The lack of adequate laboratory services is the most critical roadblock to the implementation of lead screening in a variety of existing child health programs. Grants will be used to develop State level laboratory capabilities in lead analysis, in setting and enforcing standards, and in providing technical assistance and monitoring the performance of local laboratories. New screening procedures, as they are developed and evaluated, will be incorporated into existing programs.

HEALTH SERVICES ADMINISTRATION
BUREAU OF COMMUNITY HEALTH SERVICES
Activities Related to Childhood Lead-Based Poisoning

The Bureau of Community Health Services is responsible for administering programs and projects funded under Title V of the Social Security Act to promote the health of mothers and children. In the area of childhood lead-based paint poisoning, its activities may be summarized as follows:

Public Education

MCHS pioneered public education and Federal activities related to childhood lead poisoning when it was still a part of the Children's Bureau. In 1967, it published Lead Poisoning in Children, which became instrumental in generating public as well as governmental awareness of the problem. Shortly after its publication, the booklet was reprinted and distributed by the Lead Industries Association. So far, 113,000 copies have been reprinted by the Lead Industries Association. In addition, BCHS/MCH has distributed free over 20,000 copies of the publication to State and local health departments, Crippled Children's agencies, Children and Youth Projects, Mental Retardation Services, schools of public health, libraries, Department of Health, Education, and Welfare regional offices and other governmental and private agencies. Thousands of these booklets have been sold separately by the Government Printing Office. This booklet is expected to be revised in the near future.

This initial publication was followed by a number of other public education materials which produced further impact on the problem: "Childhood Lead Poisoning - An Eradicable Disease" (Children, January - February 1970, reprinted by MCHS); "Selected Bibliography on Lead Poisoning in Children" (DHEW Publication No. 72-5105, 1971); "Watch Out for Lead-Paint Poisoning" (DHEW Publication No. 72-5101, 1972) and its Spanish version "!Cuidado La Pintura de Plomo Envenena!" (DHEW Publication No. 72-5106, 1972). "Watch Out for Lead-Paint Poisoning" was written for the population at risk, and since its publication, approximately 430,000 copies have been distributed; about 100,000 copies of the Spanish version have been printed for distribution. "Undue Absorption of Lead Among Children - A New Look At An Old Problem" was published in the New England Journal of Medicine in March, 1972 and reprinted by MCH for distribution. This paper stresses the concept of prevention of lead poisoning through early identification of children with evidence of undue lead absorption before they become poisoned and permanently damaged. The article has been particularly well received by the scientific community as attested by the large number of requests for reprints. "Preventing Lead Poisoning in Children" appeared in the Jan.-Feb. "Children Today." This paper summarizes some recent information about this disease such as its occurrence outside of the inner cities, and the many sources of hazardous lead exposure other than lead-based paint. This paper was reprinted by MCH for distribution. Another paper entitled "Vulnerability of Children to Lead Exposure and Toxicity" was published recently in two parts, in the Medical Progress Section of the New England Journal of Medicine (Dec. 6 and Dec. 13, 1973). Requests for reprints of this paper have been very heavy and include several from foreign countries.

Children and Youth Projects

In FY 1973, 62 Children and Youth Projects were funded through the Bureau of Community Health Services totaling $42,200,000. As of September 30, 1973, there were 514,790 registrants in the C&Y Projects. Among new registrants, 64% were black and other non-whites, 36% were white.

The C&Y projects provide comprehensive health care for children of preschool and school age in low-income areas, and cover on a continuous basis, the whole range of medical, dental, and emotional health needs of the children. Many projects include screening for lead poisoning as part of their health maintenance program, but the comprehensive nature of these projects makes it impossible to determine the exact amount of money spent on lead poisoning prevention and control.

Of 49 projects that responded to a recent survey on the problem of lead poisoning, 51% stated that lead poisoning was a public health problem and 49% stated that it was not. Among the 49 projects, 2 routinely tested all children seen by the project, 12 routinely tested all children under 6 years of age, 20 tested only children considered high risk for lead poisoning, and 15 reported no testing. 18 projects reported that a total of 922 children were treated for lead poisoning for the 12-month period ending September 30, 1972.

The following are some activities related to childhood lead poisoning as reported by the C&Y Projects:

In the District of Columbia, the Children and Youth Project at Children's Hospital participated in the City Lead Poisoning Committee's screening program. For a 4-month screening period in 1972, 47 percent of newly screened children were found to have blood lead levels indicative of excessive exposure to lead (40 ug/100 ml or more) in June-July, and 52 percent to have such blood lead levels in August-September. The program uncovered a number of children with elevated blood lead levels who did not live in dilapidated housing and/or did not have a history of pica. This suggests that sources other than lead paint may have contributed to the problem of undue lead absorption in these children.

Many houses within the immediate neighborhood of the Johns Hopkins C&Y Projects were built when lead-based paint was extensively used for interiors. From the outset, the project has made efforts to determine blood levels of lead in children where there is a suspicion that pica may exist. Over the past year and a half, there have been intensive efforts to screen children below the age of 5 who live in environments with access to leaded paint. About 230 children have identified with levels over 40 ug/100 ml. These children are being followed at regular intervals and their homes are being investigated for possible sources of leaded paint.

In Chicago, 116,261 children were screened for lead poisoning over a 3-year period in a cooperative effort with the C&Y Project, Chicago Board of Health, the State Health Department, and OEO. Over 10,000 children had high lead levels...The Brookdale Hospital C&Y Project in Brooklyn, New York, has put a great deal of effort into lead paint poisoning control and has relocated 60 families into public housing over a 2-year period...A grant from the Regional Medical Program, will permit the screening for lead poisoning of all children registered for C&Y services in New Hampshire...In Massachusetts, C&Y Project nurses have been giving special emphasis to screening and counseling activities for lead poisoning control.

Several C&Y projects in New York City and Baltimore have organized house-to-house surveys to screen children for lead poisoning, to alert parents to the hazard, and to locate homes with deteriorating lead-painted surfaces. The projects not only screen and treat children but also work with landlords, community groups, and official agencies to remove this danger to children...The C&Y Project at the University of Louisville has diagnosed and treated 11 cases of lead poisoning during a 5-year period. Most of these children are from the inner city area. No deaths have resulted nor is there evidence of encephalopathy among these children...Arkansas's C&Y Project is mapping out a program to find out whether lead poisoning constitutes a hazard to the project population in Greater Little Rock. A survey was undertaken during the summer of 1972 of acutely ill children seeking care at Arkansas Children's Hospital; 500 children were selected for blood testing without regard to their symptomatology.

State Maternal and Child Health and Crippled Children's Programs

Lead poisoning and possible lead poisoning have been made reportable diseases in Pennsylvania during the past year. Regulations for reporting childhood lead poisoning were circulated among hospitals, physicians, and laboratories. A procedure for lead poisoning examination in child health conferences has been recommended to the State health department's regional medical directors...In Ohio, the medical director and nursing consultant for the Division of Maternal and Child Health are working with a committee involving six divisions of the State health department in completing a plan to prevent, detect, and treat lead poisoning.

In 1971, the Model Cities Commission gave a grant to the District of Columbia Community Health Services Administration to screen children for lead poisoning. 22,000 children were tested and 25% found to have blood lead levels of 40 ug/100 ml or more. In FY 73, 8,858 children between 9 months and 6 years were tested throughout the District of Columbia. Over 30% had elevated blood lead levels.

A special project in the Lansing, Michigan area is financed through MCH funds to screen children for blood lead levels and anemia...In Minnesota, guidelines for a statewide lead poisoning control program are being developed. The department is now providing analyses of lead levels in urine and blood samples submitted by practicing physicians. Positive findings are reported to the MCH Section, which is responsible for necessary nursing follow-up...In Texas, screening for lead poisoning is not being done routinely, but the recent incident in El Paso suggests a need for screening, particularly in areas in which air, soil, or water is polluted from industries producing lead waste, as well as in areas of old deteriorated housing...In Oklahoma, the Tulsa City-County Health Department conducted a pilot study in high-risk population and detected three children with borderline elevated blood levels. A proposal has been submitted to develop a program in the area...In New Jersey, new legislation became effective January 1972 to give the State health department responsibility for maintaining surveillance over a lead poisoning control program. Laboratory services were provided for individual patients and community screening programs throughout the State through the Division of Laboratories. This activity was administered and funded by the maternal and child health program. The health department has sent each newly licensed physician publications concerning the diagnosis of lead poisoning in children and the roles of the physician and hospital in controlling lead poisoning. The MCH program gave assistance in planning, executing, and evaluating programs for the control of lead poisoning in Camden, Cape May County, East Orange, Elizabeth, Gloucester, Hoboken, Jersey City, Orange, Passaic, Paterson, Plainfield, Trenton, and Union.

The Lead Poisoning Control Program in the Connecticut State Health Department is assigned to the Division of Preventable Diseases. During licensing visits to pediatric services in hospitals, nurses try to check on donated toys to assure their safety. Distribution of literature on lead poisoning by hospital personnel is encouraged.

Research Grants

Under its research grants, BCHS supported a study of micro tests for childhood lead poisoning at the Johns Hopkins University in FY '71 amounting to $56,718. The study, also supported partially by other grants was extended and completed in February 1972. Results of the study are being prepared for publication. The findings should contribute to achieving accuracy and reliability of the various micro techniques used for screening lead poisoning in children now under investigation or field trial, and also facilitate monitoring of the many laboratories that will be performing such tests in screening programs.

Two research proposals to investigate the effect of lead exposure during pregnancy on the mother and fetus have been submitted for review. One proposes to study pregnant women in a lead-mining area, the other - pregnant women in the urban environment where exposure to lead though greater than in the rural areas, is generally considered to be relatively "low". Exposure to cadmium and other trace elements will also be investigated in these studies.

Consultation

The pediatric consultant in BCHS, Dr. Jane S. Lin-Fu, devotes much of her time to the problem of childhood lead poisoning. Her advice has been sought not only by State and local health agencies but also by congressional committees and members of Congress, the President's Committee on Mental Retardation, the Environmental Protection Agency, The American Academy of Pediatrics, as well as DHEW committees and agencies and a variety of other groups.

She helped develop the PCMR Position Statement on the problem which was released recently. She also served as consultant and contributor to the National Academy of Science in the preparation of its exhaustive study entitled "Airborne Lead in Perspective", published in 1972.

OFFICE OF HUMAN DEVELOPMENT

Office of Child Development

Lead-Based Paint Poisoning

In July 1969, the Office of Child Development (OCD) was established in the Office of the Secretary, HEW, to serve as a point of coordination for Federal programs for children and their families and to act as a national advocate of services for children. On April 1, 1973, OCD became a part of a new Office of Human Development at HEW which focuses on groups of Americans with special needs.

In localities where lead paint is a hazard, children in Head Start and other OCD demonstration programs, such as Home Start and Parent and Child Centers, are screened for lead poisoning. Children who test positively are then referred for continued medical treatment. In arranging for detection and medical care, the Office of Child Development's early childhood programs are making use of the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program (Title XIX).

The Office of Child Development's lead paint poisoning activities are primarily focused on creating public awareness of the lead paint problem. Films and pamphlets are used to inform parents of the hazarrd of peeling paint and to instruct them in prevention and control measures.

RUBELLA

Obligations for Immunization

	1971	1972	1973	1974 estimate	1975 estimate
Center for Disease Control:					
Grants..........	$16,000,000	$17,000,000	$10,050,000	$10,650,000[1/]	$6,200,000
Direct operations....	913,000	1,042,000	1,040,000	1,228,000	1,262,000
Total........	16,913,000	18,042,000	11,090,000	11,878,000[1/]	7,462,000

A new live virus vaccine was licensed for use in the United States in 1969. Later that year, project grants were awarded to State and local health agencies to assist them in planning, developing, and conducting immunization programs to control and prevent the spread of rubella and reduce the occurrence of mental retardation, blindness, and other complications associated with congenital rubella syndrome. Because of the likelihood of a rubella epidemic in 1970-72, it was necessary that the new vaccine be administered to as many susceptibles as quickly as possible. By the end of 1973, approximately 44 million doses of rubella vaccine had been administered - over 34 million doses in public immunization programs alone. No other vaccine has been so widely used so soon after licensure.

As a result, the rubella epidemic predicted for 1970-72 did not materalize. In fact, reported cases of rubella declined from 56,552 in 1970 to 27,928 in 1973. It is estimated that the intensive rubella immunization program has, at least temporarily, prevented as many as 2.5 million cases of rubella and 20,000-25,000 cases of congenital rubella syndrome. However, the threat of rubella and its complications is still great since an estimated 6.0 million preschool-age children remain unprotected against this disease.

[1/] Includes $4,450,000 of FY 1973 funds restored in FY 1974.

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